PJ Beauty Bar (Cosmos Aesthetics Ltd.)

Aesthetics Procedure Consent Form and Record Declaration

I hereby consent to having the following procedure(s) done by a practitioner at PJ Beauty Bar:

- ☐ Microneedling
- ☐ Laser Treatment
- ☐ Permanent Makeup (Eyebrows, Lips, Scalp, Eyeliner)
- ☐ High Frequency / Lymphatic Drainage Facial / Other Facials

Declaration by the client receiving treatment

I have received sufficient information about the aesthetic treatment, and I fully understand the aims and objectives of the treatment. I am aware of the limitations, possible risks, and unexpected side effects that may not be anticipated beforehand. I also understand the range of expected results, which has been explained to me by the practitioner performing the treatment(s). I understand that local anaesthetic may be applied. I have had the opportunity to consult with a qualified professional about the procedure(s) I am about to receive and have had all my questions answered to my entire satisfaction. Having considered all aspects, I have decided to have this/these treatment(s) of my own accord. I understand that I will not be able to sue my practitioner in case of any complications or be entitled to a refund if I am not happy with my procedure. I agree to follow the post treatment advice provided.
I hereby consent to the treatment described herein. I further consent to be photographed before, during, and after treatment. I understand that these photographs would remain the property of the professional practice and may be used for marketing purposes.

☐ Full Face ☐ Cropped Images ☐ I do not consent to my images being used for marketing.

Name

First Name _____ Last Name _____

Signature

_____

Date

_____

Day/Month/Year

Personal Information

Name

First Name

Last Name

Email

example@example.com

Phone Number

Country Code

Area Code

Phone Number

D.O.B.

Day/Month/Year

Health Questionnaire

Are you pregnant or breastfeeding?

- ☐ YES
- ☐ NO

Do you suffer from needle phobia?

- ☐ YES
- ☐ NO

Do you have a tendency to Keloid/excessive scarring?

- ☐ YES
- ☐ NO

Have you undergone any surgical procedure in the past 6 weeks?

- ☐ YES
- ☐ NO

Have you ever tested positive for HIV or Hepatitis B/C?

- ☐ YES
- ☐ NO

Have you had an abnormal reaction to such a procedure before?

- ☐ YES
- ☐ NO

Do you have a tendency to develop cold sores, or had one in the past 2 weeks?

- ☐ YES
- ☐ NO

Are you taking HRT, Steroids, or Blood thinners (anticoagulants, blood thinners e.g. Warfarin, Aspirin)?

- ☐ YES
- ☐ NO

Have you taken any Antibiotics in the past week in the area to be treated?

- ☐ YES
- ☐ NO

Do you have any permanent implants?

- [ ] YES
- [ ] NO

Do you suffer from eczema or psoriasis?

- [ ] YES
- [ ] NO

Do you suffer from active acne?

- [ ] YES
- [ ] NO

Have you ever been diagnosed with Angina (Chest Pain)?

- [ ] YES
- [ ] NO

Have you ever been diagnosed with Diabetes?

- [ ] YES
- [ ] NO

Have you ever been diagnosed with Epilepsy?

- [ ] YES
- [ ] NO

Have you ever been diagnosed with Hepatitis A?

- [ ] YES
- [ ] NO

Have you ever been diagnosed with Severe mental condition, requiring medication?

- [ ] YES
- [ ] NO

Have you ever had a reaction to local anesthetic (numbing cream / injection)

- [ ] YES
- [ ] NO

Have you been diagnosed with any other medical condition not mentioned above? Please give more details.

If you said YES to any of the above, please indicate which medications you are currently taking

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If you are contra indicated, you may be referred to your General Practitioner for permission to do procedure. Your treatment may be referred or refused.

By signing below, I certify all information is true and correct to the best of my knowledge.

Name

First Name

Last Name

Signature

Date

Day/Month/Year