**Client informed consent and consent agreement for lash / brow tinting and /or waxing for Om SPA,LLC**

**Full Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home/Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROCEDURE TYPE (MARK ALL THAT APPLY) :** lash tint, brow tint, eyebrows wax, body wax

*Have you ever used hair color before? Yes/No*

Have you ever had an allergic reaction to hair color? Yes/No

*Do you wear contacts? Yes/No*

Have you ever had your brows or lashes tinted and brow’s or body waxed? Yes/No

*If you had an adverse reaction to a previous tinting and /or waxing, please explain:*

……………………………………………………………………………………………………………………………………………………..

Have you used any Retin-a, Renova or Accutane, Alpha Hydroxy Acid (AHA) or glycolic, salicylic or other acids skin care products or done any chemical/enzyme peels, photo-facial, laser treatments, body piercing in the past 72 hours? Yes/No

*Are you using any other skin thinning products and/or drugs, steroids? Yes/No*

Do you use a tanning bed or spray tanning? Yes/No

Are you exposed to sun on a daily basis or are you considering spending more time in the sun soon? Yes/No

*Please, list any allergies you have including a food allergy:*

*………………………………………………………………………………………………………………………………………………………*

Please list any medications you are taking, including over-the-counter herbs, vitamins and supplements:

………………………………………………………………………………………………………………………………………………………………….

Do you have diabetes, lupus, or any auto-immune disease? Yes/No (If yes, describe)

…………………………………………………………………………………………………………………………………………………

Have you ever been treated for cancer? If yes, when and what types of therapies were used?

…………………………………………………………………………………………………………………………………………………………………

*Please list any other illnesses or conditions you are being treated by a physician for or recently done surgeries or beautifying treatments: ……………………………………………………………………………………………………………………*

(Female clients only) When is your next menstrual cycle due to begin? ………………………….

 *(Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed.)*

*(Male clients only) How many days ago did you shave last time?............................................*

Although every precaution will be made to ensure your safety and well-being before, during and after your tinting and /or waxing application service, please be aware of the possible risks below. Please initial:

………….. I understand that tinting lashes or brows has some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in stinging or burning, blurry vision and potentially blindness should the tint enter into the eye.

………….I understand that if the tinting agent, developer, or mixture of both accidentally comes into contact with my eye, my eye will be flushed with water and medical attention may be required.

…………..I understand that some irritation, itching or burning may occur to the skin which comes in contact with the tinting agent.

………….. I understand that there may be some residual dark staining left on the skin following the tinting process of either my lashes, brows or both. This will fade and go away within a short time.

…………. I understand that, while every attempt will be made to provide me with my chosen color, everyone’s hair absorbs color differently and my final results may not be the color I initially wanted.

………… I understand that over the course of several weeks, the tint will gradually lighten and fade. Re-tinting will be required to keep the new color fresh. Most clients need to re-tint every 3-4 weeks.

…………Please note that waxing does have certain side effects, that might occur immediately or delay, such as skin removal, redness, swelling, tenderness, etc. Other side effects/risk are: allergic reaction to the waxing products, potential skin scarring, hyper or hypo pigmentation, skin deep burn, folliculitis and infection especially if not follow proper after care, folliculitis

 ………….I agree strictly follow to waxing after care regiment: no swimming pools, saunas, hot showers, sweating, sun exposure or bed/ spray tanning, no body treatments, peels/exfoliation, body tattoos, piercing done on freshly waxed area within 72 hours after waxing. Having intimate intercourse within next 24 hours is not recommended. Only gentle skin care lotion can be applied on skin.

…………I have read the above information and if I have any concerns, I will address these with my skin therapist. I give permission to my therapist to perform the waxing procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible.

…………I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home product / post-treatment care, I will consult the esthetician immediately.

………………I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure(s) and accept the risks. I do not hold the Om SPA LLC and its stuff, employees, affiliates, subcontractors, estheticians, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of the lash/brow tint and waxing or body waxing procedure, which may be affected by the treatment performed today and in the future. It is my responsibility to inform my esthetician if my health condition would change at any time before treatment begins. I hold on this consent form as long as I am returning OM SPA LLC client.

Client Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Esthetician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_