Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Parent/Guardian (If Client under 18 years of age) Print Name: _____

The following problems may occur with the above treatments:

1. There is a risk of scarring.

2. Short term effects may include reddening, mild burning, temporary bruising, or bleeding. Hyper-pigmentation (browning) and hypopigmentation (lightening) have also been noted after treatment. These conditions usually resolve themselves, but, while rare, permanent color change is a risk. Avoiding sun exposure before and after the treatment reduces the risk of permanent color change.

3. Infection - Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Individuals with a history of herpes simplex who receive laser treatment in the affected areas can create an outbreak.

4. Bleeding - Pinpoint bleeding is rare but can occur following treatment procedures.

5. Allergic Reactions - In rare cases, local allergies to tape, preservatives used in topical preparations and products have been reported.

6. Systemic reactions (which are more serious) may result from prescription medicines. Do not take blood thinning medications three days prior to treatment and three days after (Consult physician prior to discontinuing any medication).

7.Clients with a history of keloid scarring, skin cancer, eczema, psoriasis, diabetes, heart condition, moles, sun damaged skin, vitiligo, alopecia, hemophilia, HIV-AIDS or any other communicable disease and/or relevant medical condition should consult their medical doctor before undergoing SMP treatment.

8. Deposit and Color issues- Body can reject ink material causing ink to travel, not deposit into the skin and/or appear a different color.

9. Compliance with follow-up appointments, before and aftercare guidelines is crucial for healing, prevention of problems, scarring, discoloration, hyperpigmentation and risks. There is also the possibility that other side effects or complications not presently known, recognized, described to you now or understood may develop now or in the future. A few side effects, risks, and complications can occasionally be seen. These include, but not limited to the following complications.

The following risks, side effects, and complications are rare, however possible, and temporary:

- Itching on or around area treated
- Redness around hair follicles
- Swelling around hair follicles
- Tingling or feeling of numbness
- Purpura (purple bruising)
- Infection (primarily due to picking the area treated)
- Pigment change (ink, hypo, hyper)
- Crusting/scab on ingrown hairs

I acknowledge by signing this release form that I have been given the full opportunity to ask any questions I might have about SMP treatment from OTM Skin. I acknowledge that all my questions have been answered to my full and total satisfaction. I specifically acknowledge that I have been advised of the facts and matters set forth below, and I agree and represent as follows:

____ I am not under the influence of alcohol or drugs

____ I confirm that I am not pregnant

____ I am 18 years of age or have parent/guardian consent attached

____ I acknowledge that it is not reasonably possible for the associates, agents, and representatives of OTM Skin to determine whether I might have an allergic reaction to the tools / products used during SMP treatment and I agree to accept the risk of an allergic reaction.

____ I acknowledge that infection is a possible result of obtaining SMP treatment particularly if I do not take proper care of skin treated, and I have been advised of the before/aftercare of treatment.

____ I acknowledge receipt of written instructions advising me of proper before and aftercare of my treatment and recognize the absolute necessity of following those instructions.

____ I acknowledge that variations in skin color, condition, age and texture may affect the results of any SMP treatment.

____ I acknowledge that SMP is a semi-permanent change applied to my body.

____ I acknowledge that obtaining SMP is my choice alone and I consent to the application of SMP.

____ I acknowledge that SMP can cause itching, bleeding, bruising and/or scabbing and if there is a history of herpes the laser treatment can trigger an outbreak around mouth, nose or eyes.

____ I agree to release and forever discharge and forever hold harmless OTM Skin and its associates, agents' officers and shareholders from any claims, damages, or legal actions arising from or connected in any way with my SMP treatment.

____ I agree to allow OTM Skin to take before/after photos of my tattoo removal treatment for the client profile and to promote OTM Skin portfolio purposes unless otherwise advised in writing by the client.

I, _____have been fully informed of the risks of SMP including but not limited to infection, scarring, bleeding, brushing, herpes outbreak, difficulties in depositing ink material, and any allergic reaction. Having been informed of the potential risks associated with getting SMP, I wish to proceed with SMP application, and I assume all risks that may arise from treatment.

Signature_____ Date: _____

Parent or Guardian_____ Date: _____

Parent/Guardian Signature_____ Date: _____

About you:

• What is your hereditary background? (circle all that apply) Nordic / Scandinavian / Irish / English / Asian / Mediterranean / Hispanic / Native American / Middle Eastern / African American / Other _____

• Natural eye color: _____

• Natural hair color: _____

• Do you consider your skin (circle the best option): Sensitive / Resilient / Unsure

• Describe your skin (circle all the apply): Normal / Dry / T-Zone/Combination / Thick / Thin / Saggy / Firm / Oily / Acne / Comedones /Blackheads / Milia / Cysts / Breakouts / Acne-scarred / Large pores / Small pores / Rosacea / Eczema / Freckled / Sun-damaged / Melasma / Hyperpigmentation / Hypopigmentation / Uneven/Blotchy / Mature / Wrinkled / Patchy dryness / Sallow / Psoriasis / Dehydrated/Lacking moisture / Asphyxiated / Broken surface capillaries

• What are the changes you would most like to see on in you (circle all that apply): Scar Fill / Restore Hairline / Density Fill / Full Head Fill / Other _____

Lifestyle:

• Are you pregnant or lactating? □ No □ Yes (**Please consult with your obstetrician.** • Do you have any skin conditions, concerns or issues? □ No □ Yes _____

• Are any of these conditions, concerns or issues currently active? □ No □ Yes _____

• Are you in the habit of going to tanning booths? □ No □ Yes (If within past 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)

• Do you participate in vigorous aerobic activity or sports? □ No □ Yes What type? _____

• Do you smoke or use tobacco? □ No □ Yes

• What kind of work do you do? _____

• On average, how many hours per week do you spend outdoors? _____

• Do you currently use depilatories or wax? □ No □ Yes (Discontinue use five days pre- and post-treatment.)

Medical/treatment history:

• Have you had a hair transplant or any other procedure on scalp? □ No □ Yes

• Have you used prescription or over the counter hair growth products on your scalp within the last 14 days? □ No □ Yes What type? _____

• Are you currently taking any blood thinning medications, topical or otherwise? □ No □ Yes (Apixaban (Eliquis), Dabigatran (Pradaxa), Heparin, Aspirin) High percentages of certain prescription ingredients may increase sensitivity. Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)

• Do you develop cold sores/fever blisters? □ No □ Yes Last breakout? _____

• Are you allergic/sensitive to (circle all that apply) metals / charcoal / aloe vera / perfumes / latex / hydroquinone / lidocaine? If any other allergies, what? _____

• Have you ever used any other products that caused a bad reaction? □ No □ Yes
Describe: _____

Patient signature: _____ Date: _____

Clinician signature: _____ Date: _____

For Office Use: **Treatment area & description**

Notes: _____

_____

_____

_____

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_____

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_____