



Acknowledgement and consent form

for pigment (tattoo) lightening procedure

- ☐ The nature and method of the proposed treatment (cosmetic tattoo) lightening procedure has been explained to me including the risks or possibility of complications during or following the procedure.
- ☐ I understand there may be a certain amount of discomfort or pain associated with the procedure, and that adverse side effects may include minor and temporary bleeding, bruising, swelling, redness, or other discolouration. I understand that fever blisters may occur on my lips following lip procedures if I am prone to this problem.
- ☐ I understand that secondary infection may occur in the area of the procedure, but that this is rare if I properly adhere to after care.
- ☐ I understand that several treatments may be needed in order to attempt to achieve my desired results. However, I have not received any guarantees with respect to the quality of the end result.
- ☐ I understand that there are medical options available for pigment (tattoo) removal. I have decided to decline those methods.
- ☐ I understand that the unwanted pigment may not be successfully lightened to the point it can no longer be seen.
- ☐ I understand that scarring as hyperpigmentation or hypopigmentation, or other damage to the skin may occur during this process and may be permanent. I will not hold my technician and/or the distributor of tattoo removal products used in this attempted pigment (tattoo) removal liable for any damages that may occur to my person.
- ☐ I understand that lightening tattoo pigment is difficult, if even possible. As a result, I will not hold my technician or this establishment responsible for any resultant failure to lighten the unwanted pigment.
- ☐ I understand that if I am Fitzpatrick classification skin type V or VI, or am undergoing saline removal procedure, I am at a higher risk for hyperpigmentation and hypopigmentation, and agree to the risks involved.
- ☐ I agree to follow after care instructions provided to me by Clynic.
- ☐ I have been duly informed of the nature, risks, possible complications and consequences as listed above. I further understand that my technician is not a medical doctor.
- ☐ I accept the risks associated with this procedure.
- ☐ I understand that all semi permanent procedures carry with them the possibility of complications and consequences including but not limited to fading of skin pigments, risk of infection, scarring, eye damage, inconsistent colour, and bruising.

- ☐ I understand that if I would like the best results from the procedure, I will need to book a 4-6 week follow up appointment.
- ☐ I understand that the actual colour of the pigment may be modified slightly as a result of the tone of my skin.
- ☐ I understand that having a lip procedure may inflame cold sores. If I am susceptible to cold sores, I have advised my therapist of this, consulted with my doctor, and received treatment (eg. Zovirax, Famvir).
- ☐ I have received detailed instructions on the aftercare of my treatment and I will strictly adhere to these instructions. I accept responsibility for all aftercare of my treatment, and understand that if not carried out correctly, may result in fading of skin pigments, infection, scarring, or inconsistent colour.
- ☐ I understand that the therapist takes no responsibility for any possible complications or consequences that may result from the procedure(s), particularly if I have neglected to answer questions properly, failed to accurately disclose my medical history, or neglect any aspect of pre or post treatment care instructions provided to me by Clynic.
- ☐ I consent to the information on this form being used to provide best practice treatment at Clynic. I understand that the information in this form and associated with treatment will be held in accordance with the Australian Privacy Principles and the Privacy Statement located on the Clynic website, or on request from my therapist.
- ☐ I consent to Clynic contacting my GP regarding any aspect of my medical history where it may impact any treatments I have requested.
- ☐ I am over the age of 18 and not under the influence of alcohol or other drugs. I agree to the terms and conditions, and declare that, to the best of my knowledge, the information I provided above is true and correct. I consent to the procedure(s) indicated above be performed on me.

Name _____

Signature _____ Date _____

_____ Date _____

Witnessed by technician performing the removal/lightening procedure

Therapist's notes
