YOUR WELLNESS CENTER
WEIGHT LOSS, HORMONE REPLACEMENT & MEDSPA

EYELASH EXTENSION CONSENT

Initial the following lines:

_____ I understand that a full set of lash extensions can make the appearance of my own lashes about 30-50% thicker, and make my lashes appear 20-50% longer.

_____I understand that lash extension services have some inherent risk of irritation to the orbital eye area, including the eye itself, and could result in stinging and burning, blurry vision and potential blindness should the adhesive enter the eye or should an allergic reaction occur.

_____ I understand that some irritation, itching or burning may occur on the skin if the bonding agent comes into contact with it.

_____ I understand that if the bonding agent comes into contact with my eye, my eye will be flushed with water and I will be assisted in seeking medical attention immediately.

_____I understand that this is a semi-permanent procedure, as my natural lashes will continue to grow and fall out normally, making touch-up or "fill" appointments necessary to maintain the original look achieved by replacing the lashes that have fallen out. Most clients require a fill appointment every 2-3 weeks.

_____ I understand that while every attempt will be made to provide me with the length and fullness I have chosen, my final result may not be what I initially envisioned.

_____I understand that it is imperative that I disclose all of the information requested in the Client Profile/Health History.

_____ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

_____ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

_____ DISCLAIMER: I understand the nature of the procedure to be performed, the contraindications, side effects, risk, and complications. I acknowledge that I have been given the opportunity to ask any questions regarding the procedure, and these questions have been answered to my satisfaction. I understand the pre and post care instructions and how crucial they are for the success of the treatments. By not following the pre and post care instructions, I understand side effects and complications may occur. Although good results are expected, there is no guarantee on the results that may be obtained. I hereby give my unrestricted informed consent for the procedure and subsequent treatments. I hereby release the providers and the facility from liability associated with this procedure. I am aware this is a cosmetic procedure and I am fully responsible to pay for the entire amount charged. I understand no refunds for any treatment may be rendered, regardless of the results. I understand it is my responsibility to inform the office staff of any medical changes that have occurred, including any contraindications to the list above.

Printed Patient's Name: _____

Patient's Signature: _____ Date: _____