BELLA VIA
Skin and Body Therapies

Affiliated with Reconstructive & Aesthetic Surgeons, Inc.
419.534.6551 • www.RASInet.com

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Lash Lift Consent Form

_____ Do not perform *Lash lift* if any of the following contraindications exist: Blepharitis, Keratitis, Alopecia, Trichotillomania, Bells Palsy, Sjogren's Syndrome, or any disease/disorder that causes shaking and/or twitching.

_____ I agree to get a doctors referral if I am a post Chemotherapy patient, have glaucoma or have dry eye syndrome.

_____ I understand that there are risks associated with having this procedure. I further understand that the procedure eye irritation, eye pain, eye itching, discomfort, and in rare cases, eye blurriness or infection can occur. I agree that if I experiences any of these conditions with my lashes, I will contact my technician and consult a physician at my own expense.

_____ I understand that there are no guarantees as to the results of this treatment due to many variables such as age, condition of skin, climate, etc.

_____ I understand that though my technician uses proper technique, instruments, adhesive, tape, cleansers, eye gel pads, and removers, my eyes may become temporarily irritated or in rare cases, require a physician's care. I release my technician from all liability associated with the procedure, which is performed with utmost attention to safety and proper application using tools and products that the technician has been professionally trained to use.

_____ The treatment that I will receive has been explained to me by my esthetician.

_____ I understand that this procedure is semi-permanent.

_____ I understand and consent to having my eyes closed and covered for the duration of the procedure.

_____ I understand and consent to removing contact lenses prior to the procedure.

_____ I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-treatment care instructions as I am directed.

_____ I consent to having "Before" and "After" photographs of all procedures for the purpose of documentation in my file. These photographs **may** _____ or **may not** _____ (please initial one) be used anonymously on our website or in our brochure for advertising purposes.

_____ I certify that the above statements are true and correct, and that I, _____ , having been advised and fully informed by my esthetician, _____ of Bella Via, concerning the nature of the service proposed and hereby authorize and direct them to perform this service as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that I have read, understand and fully agree to the foregoing. I understand the caution and contraindications for the service proposed; give consent to the proposed service that has been satisfactorily explained to me and have all the information that I desire. I hereby give my consent and authorization voluntarily and release Bella Via Skin and Body Therapies and its agents of any claims that I have or may have in the future in connection with the described application or service.

Recommended Procedure: _____ **Price:** _____

Client Signature: _____ **Date:** _____

Technician Signature:_____ **Date:** _____

Office Use Only: Verbally Confirm

Cancer		Phlebitis/Thrombosis	
Pregnancy		HIV/Herpes/Hepatitis	
Epilepsy		Medications	
Seizures		Accutane	
Lupus		Pacemaker	
Diabetes		Other	

Signature/Date: _____