ZH
Glowing Beauty Studio

LASH LIFT & TINT

+

BROW LAMINATION

DIGITAL FORMS

CLIENT NAME:

LASH LIFT & TINT
BROW LAMINATION

CLIENT INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

How did you hear about us? _____

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

Lash Lift Contraindications

- ☐ Dry Eye Syndrome
- ☐ Chemotherapy
- ☐ Sensitive eyes
- ☐ History Of Eye infection
- ☐ Ocular Rosacea
- ☐ Sjorgen's Syndrome

Brow Lamination Contraindications

- ☐ Alopecia
- ☐ Chemotherapy
- ☐ Eczema
- ☐ Psoriasis
- ☐ Super Sensitive Skin
- ☐ Sunburn
- ☐ Wounds In Treatment Area
- ☐ Recent Facial Treatment
- ☐ Retinol, AHA, BHA etc.

Any allergies to adhesive tape, fumes or eye remover? ☐ No ☐ Yes

Previous allergies/sensitivities to lash lift, tint or brow lamination? ☐ No ☐ Yes

Are you pregnant or breastfeeding? ☐ No ☐ Yes

LASH LIFT & TINT
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CLIENT INTAKE FORM

Do you wear contacts? ☐ No ☐ Yes

Do you use eye drops of any kind? ☐ No ☐ Yes

Do you use oil-containing sunscreen or moisturizer around the eyes? ☐ No ☐ Yes

List any medications/supplements you take regularly: _____

_____

Have you recently had lash extensions/lash lift or brow lamination? ☐ No ☐ Yes

If yes, when? _____

Any recent semi-permanent makeup (brows, liner)? ☐ No ☐ Yes

If yes, when? _____

I consent to have my eyes closed and covered for the duration of the 45-90 minute procedure. ☐ No ☐ Yes

By signing below, you agree to the following:
I am over 18 years of age and have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition/s that would make the requested treatment unsuitable. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health.

_____ _____

Client Name (printed) : *Date*

_____ _____

Client Name (signature) : *Date*

LASH LIFT & TINT
BROW LAMINATION

CONSENT FORM

I hereby consent to and authorize _____ to perform the following procedure: _____.

Please initial each statement:

_____ I agree to have an eyelash lift, brow lamination and/or eyelash tint applied to my natural eyelashes and/or retouched. By signing this agreement, I consent to the procedure of an eyelash perm, brow lamination or eyelash tint by my technician.

_____ I understand there are risks associated with having an eyelash perm, brow lamination and/or eyelash tint. I further understand that as part of the procedure, eye irritation, eye pain, eye itching, discomfort, and in rare cases eye infection or blurriness could occur.

_____ I agree that if I experience any of these medical conditions with my lashes that I will contact my technician and consult a physician at my own expense.

_____ I understand that even though my technician perms the lashes/brows using the proper technique, the instruments, tapes, cleaners, eye gel pads, adhesives, and removers used may irritate my eyes/brows or require a physician's follow-up care.

_____ I understand that some mild but normal symptoms may occur with the brow lamination depending on the sensitivity of my skin during the procedure and will subside in 24 hours. These symptoms may include: mild tingling, slight redness due to brushing the hairs, slight warmth in the area.

_____ I understand that this agreement will remain in effect for this procedure and all future conducted by my technician.

_____ I have been offered the opportunity to have a patch test of the products being used. I accept full responsibility for any reaction which might occur due to undisclosed sensitivities/allergies.

_____ I understand and consent to having my eyes closed throughout the procedure.

_____ I understand that if I have any concerns, I will address these with my lash/brow technician.

_____ I will remove any contact lenses during the procedure.

LASH LIFT & TINT
BROW LAMINATION
CONSENT FORM

_____ I agree to the following Lash Lift/Tint/Brow Lamination aftercare and maintenance instructions:

- ☐ No water can come in contact with the treatment area for 24 hours after the application.
- ☐ No makeup such as mascara, eyeliner or brow pencil on the treatment area for the first 24 h.
- ☐ No skincare products or oil containing products on or around lashes/brows for the first 24 h.
- ☐ No waterproof mascara on your lifted/tinted lashes.
- ☐ No pulling or rubbing of the lashes/brows.
- ☐ If redness or irritation worsens over the course of 24 hours please contact your doctor about a potential reaction to the product.
- ☐ Do not have any type of permanent makeup or semi-permanent makeup done while your hair is still lifted, as your artist must be able to see the natural direction of the hair.

_____ I understand and agree to the care instructions provided by my technician for the use and care of my permed and/or tinted eyelashes/eyebrows. I realize and accept the consequences of failure to adhere to these instructions may cause the eyelashes to not stay permed as long as told.

This agreement will remain in effect for this procedure and all future follow-ups conducted by the certified eyelash/brow technician. I understand my lash/brow technician will take every precaution to minimize or eliminate negative reactions as much as possible. I will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. 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 and accept the risks. I do not hold the lash/brow technician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today. I have read and fully understand all information in this agreement. I am over 18 years of age and consent to the agreement and to the eyelash lift/tint/brow lamination procedure.

_____ _____ _____

Client Name (printed) *Client Name (signature)* *Date*

_____ _____

Technician (signature) *Date*

L A S H L I F T & T I N T
B R O W L A M I N A T I O N

PATCH TEST

While an allergic reaction is quite uncommon, it can still occur. It is recommended that a small amount of the products being used for treatment is applied to the client 48 hours before the service. The testing site is then monitored for local reaction.

Please fill out and initial below to confirm your understanding. If there is any sign of redness, itching, swelling or blistering, return to have any traces of adhesive removed and do not proceed with the treatment.

Do you have any allergies? _____

Please initial each statement:

_____ I understand there are risks associated with having an eyelash lift, tinting and/or brow lamination.

_____ I confirm that my provider has explained all the reactions, sensitivities and risks to me and I have been given the opportunity to ask questions.

_____ I accept full responsibility for any risks, reactions and sensitivities which may occur and I have disclosed all allergies to my provider.

_____ I understand and agree that if I experience any reaction that I will contact my provider immediately. I understand I may need to seek medical treatment at my own expense.

_____ I will not hold my provider responsible in any way for my reactions, sensitivities and injuries that might occur as a result of this treatment.

_____ My provider has given me the option of patch test, I understand that declining a patch test may result in reactions and I may be refused treatment.

☐ I consent to have a patch test done. ☐ I decline to have a patch test done.

_____ _____ _____

Client Name (printed) *Client Name (signature)* *Date*

_____ _____

Technician (signature) *Date*

LASH LIFT & TINT

AFTERCARE ADVICE

Don't get them wet for 24h.

No facials for 24h.

No makeup around the eye for 24h.

No picking, pulling or rubbing your lashes.

No oil-based products around the eye for 24h.

Avoid waterproof mascara.

No hot baths, sauna or swimming for 24h.

Avoid sleeping face down.

BROW LAMINATION

AFTERCARE ADVICE

Don't get them wet
for 24h.

Avoid direct sun /
UV light.

No makeup around the
eye area for 24h.

Avoid oil-based
products on eyebrows.

No hot baths, sauna or
swimming for 24h.

Avoid picking, touching,
rubbing your brows.

Sleep on your back the
first 24-48h.

Use a brow
conditioner daily.

LASH LIFT & TINT
BROW LAMINATION

PHOTOGRAPH AND VIDEO RELEASE FORM

CLIENT INFORMATION

Name: _____ Date: _____

Phone: _____ Mail: _____

I would like your permission to use these photos for advertising. For example: Portfolios, online and print ads, etc. Your consent is necessary regarding this. Please circle and indicate with your signature if you would like your photos used or not used in advertising. We also like to tag our clients in photos used on our Instagram profile! Please indicate if you'd like to allow this or not below.

- ☐ Yes, feel free to use them
- ☐ Yes please tag me on Instagram
- ☐ No, please do not use them
- ☐ No, please do not tag me

_____ _____

Client Name (printed signature) *Client Name (signature)*

_____

Date

LASH LIFT & TINT
BROW LAMINATION
CANCELLATION POLICY

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment you will be asked to pay a _____ deposit that will be credited towards your treatment/s.

Time has been specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule your appointment you must call at least 24 hours prior to your appointment and your deposit will either be refunded or pushed for a future appointment. However, providing less than 24 hours' notice will require you to pay a _____ cancellation fee.

If you arrive more than 15 minutes late for your appointment it is considered a no-show and you will be charged the cancellation fee.

We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.

_____ _____

Client Name (printed) : *Date*

_____ _____

Client Name (signature) : *Date*

DAILY PLANNER

DATE

GOALS

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

TO DO LIST

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

TODAY'S APPOINTMENT

TIME:	EVENTS:

BREAKFAST:	LUNCH:
SNACK:	DINNER:

NOTES

MONTHLY CALENDAR

MONTH OF

	MON	TUE	WED	THU	FRI	SAT	SUN
WEEK 1							
WEEK 2							
WEEK 3							
WEEK 4							
WEEK 5							

GOALS

PRODUCT INVENTORY

Date	Product	Quantity	Cost	Price	Profit

INVOICE TEMPLATE

Bill To: Client name
Address Line #1
Address Line #2

Invoice #:0234
Issue Date: 06/15/2022
Due Date: 07/15/2022

DESCRIPTION	PRICE	QTY	TOTAL
Item 1	$1000	1	$1000
Item 2	$1000	1	$1000
Item 3	$1000	1	$1000
Item 4	$0	1	$0
TOTAL:			$3000

SUBTOTAL:	$3000
TAX:	0
TOTAL:	$3000

YOUR BUSINESS NAME HERE

Business address here
City / State / Zip
Phone: 555-555-5555
Hello@youremail.com

PAYMENT INFORMATION

I accept the following type of payment:
Cash, Visa, Mastercard