DC

DERMAL CAMOUFLAGE CLINIC

MASTER CLIENT CONSENT FORM

Complete this form once for today's selected service. Tick the treatment being performed and initial only the consent section that applies to that treatment.

1. Client details

Full name	_____
Date of birth	_____ Pronouns (optional): _____
Address	_____
Mobile	_____ Email: _____
Emergency contact	_____ Phone: _____
Appointment date	_____

2. Select today's service

Paramedical tattooing / camouflage

☐ Scar camouflage	☐ Stretch-mark camouflage
☐ Hypopigmentation camouflage	☐ Vitiligo camouflage
☐ Burn-scar camouflage	☐ Self-harm scar camouflage
☐ Top-surgery scar camouflage	☐ Areola restoration / 3D areola
☐ Breast-surgery scar camouflage	☐ Scalp / hair-density tattooing
☐ Other: _____	

Inkless skin restoration

☐ Scar restoration	☐ Stretch-mark restoration
☐ Acne-scar restoration	☐ Other: _____

Clinical skin clearing

☐ Skin tag	☐ Milia
☐ Seborrhoeic keratosis	☐ Cholesterol deposit / xanthelasma
☐ Other lesion: _____	

LED light therapy

☐ Wound-healing support	☐ Active acne
☐ Rosacea	☐ Eczema / psoriasis
☐ Bruising / inflammation	☐ Facial / skin rejuvenation
☐ Other: _____	

Lash and brow

☐ Korean lash lift	☐ Lash lift
☐ Lash tint	☐ Brow lamination
☐ Brow tint	☐ Combined service: _____

Treatment area _____

3. Health and suitability screening

Tick every item that applies to you, then give details below. Leave items unticked if they do not apply. This information is confidential and helps determine whether treatment should proceed, be modified or be postponed.

☐ Pregnant, breastfeeding or trying to conceive	☐ Diabetes or difficulty healing
☐ Bleeding/clotting disorder or blood-thinning medication	☐ Immune suppression, chemotherapy, radiotherapy or systemic illness
☐ Heart condition, pacemaker or implanted electrical device	☐ Epilepsy or seizures
☐ Allergy/sensitivity to latex, adhesive, pigment, anaesthetic, metals, cosmetics or skincare	☐ History of keloid or hypertrophic scarring
☐ Current infection, fever, cold/flu symptoms or feeling unwell	☐ Active rash, eczema, psoriasis, dermatitis, acne, sunburn, wound or lesion in treatment area
☐ Herpes/cold sores or shingles in/near treatment area	☐ Recent surgery, injectables, laser, peel, needling, tattooing or other procedure in treatment area
☐ Taking isotretinoin/Roaccutane now or recently	☐ Using retinoids, acids, steroids, antibiotics or photosensitising medication
☐ Blood-borne virus or other condition relevant to safe treatment	☐ Skin cancer, suspicious/changing lesion or lesion not medically diagnosed
☐ Eye disorder, eye surgery, severe dry eye or contact lenses (lash/brow/LED facial services)	☐ Currently smoking or vaping nicotine

Current medications, supplements and topical products

List _____

Allergies or previous adverse reactions

Details _____

Relevant medical conditions, surgeries and treating practitioners

Details _____

Additional details for any Yes answer _____

_____

4. General consent — applies to every selected service

☐ I have provided complete and accurate health information and will tell the clinician about changes before treatment.

☐ The selected treatment, intended outcome, reasonable alternatives, limitations, likely course, aftercare and material risks have been explained to me in language I understand.

☐ I have had the opportunity to ask questions and have received satisfactory answers. I understand that I may request a pause or withdraw consent before or during treatment.

☐ I understand results vary between individuals and no particular result, colour match, symmetry, clearance, number of sessions or permanence has been guaranteed.

☐ I understand more than one session, maintenance, colour adjustment or review may be required and additional appointments may have separate fees.

☐ I consent to appropriate skin preparation, use of single-use consumables and products required to perform the selected treatment.

☐ I understand temporary redness, swelling, tenderness, itching, dryness and sensitivity can occur with many skin treatments.

☐ I agree to follow written and verbal aftercare instructions and to seek medical care for signs of infection, severe reaction, fever, spreading redness, increasing pain, eye symptoms or other concerning symptoms.

☐ I understand this clinic does not diagnose suspicious lesions or replace assessment or treatment by a medical practitioner.

This consent does not exclude any rights or remedies that cannot lawfully be excluded under Australian law. Signing confirms informed consent; it is not a waiver of the clinic's duty to provide services with due care and skill.

5. Service-specific consent

Initial ONE or more relevant sections on the following pages. Do not initial a section for a service you are not receiving today.

A. Paramedical tattooing / camouflage Client initials: _____

☐ Pigment is implanted into the skin. The healed colour may differ from the colour seen immediately after treatment and may fade, shift, heal unevenly or require adjustment.

☐ Exact skin-tone matching cannot be guaranteed. Natural tanning, ageing, hormones, medications, sun exposure and underlying scar tissue can change the contrast over time.

☐ Scar and previously treated tissue may accept, retain and heal pigment unpredictably. Patch testing reduces but does not eliminate the risk of an unwanted result or reaction.

☐ Possible risks include pain, bleeding, bruising, swelling, infection, allergic or inflammatory reaction, delayed healing, pigment migration, colour change, unevenness, scarring, keloid formation, hyperpigmentation or hypopigmentation.

☐ The procedure may need several sessions. Pigment is long-lasting and removal or correction can be difficult, incomplete and costly.

☐ For areola or breast treatment, I understand that symmetry, size, shape, colour and three-dimensional appearance are artistic approximations and cannot recreate a natural nipple or restore sensation.

☐ I will avoid treatment-area exposure and activities listed in my aftercare instructions, attend reviews as advised, and obtain medical clearance if requested.

Patch test / test spot

☐ Completed — date: _____	☐ Recommended and client consents
☐ Declined after explanation	☐ Not required / reason: _____

Pigment brand/colours and drop ratio _____

Needle/cartridge and machine settings _____

Lot/batch and expiry details _____

Treatment notes / test spot location _____

B. Inkless skin restoration Client initials: _____

☐ This treatment creates controlled skin stimulation without implanting skin-coloured pigment. It does not erase scars or stretch marks and results vary.

☐ Possible effects include pain, pinpoint bleeding, redness, swelling, bruising, itching, crusting, prolonged healing, infection, scarring, texture change, hyperpigmentation or hypopigmentation.

☐ Scar tissue may respond unpredictably. Multiple sessions may be required and improvement cannot be guaranteed.

☐ I will not pick, scratch or prematurely remove flaking/crusting and will follow all aftercare and sun-protection instructions.

Product/serum used, lot and expiry _____

Needle/cartridge and settings _____

C. Clinical skin clearing Client initials: _____

☐ The clinician is providing a cosmetic treatment only and has not diagnosed the lesion. I have disclosed any medical diagnosis or change in the lesion.

☐ Treatment may be refused or postponed and medical assessment may be required if a lesion is pigmented, changing, bleeding, irregular, uncertain or otherwise unsuitable.

☐ Possible outcomes include pain, heat/stinging, redness, swelling, crusting, blistering, bleeding, infection, delayed healing, scarring, texture change, temporary or permanent pigment change, incomplete clearance or recurrence.

☐ Several treatments may be required. I understand that lesions can recur and that complete removal without a mark cannot be guaranteed.

☐ I will follow wound-care instructions, avoid picking and obtain medical attention for concerning symptoms.

Lesion type/location and number treated _____

Method/device and settings _____

Medical clearance / diagnosis details if applicable _____

D. LED light therapy Client initials: _____

☐ LED is a supportive cosmetic treatment and is not a cure or substitute for medical treatment.

☐ Possible effects include temporary redness, warmth, dryness, headache, eye discomfort, symptom flare or an uncommon skin reaction.

☐ I have disclosed medicines and conditions that may cause photosensitivity, as well as epilepsy, lupus, porphyria and eye conditions.

☐ I agree to wear the eye protection provided and keep it in place for the treatment as directed.

☐ Results and the number or frequency of sessions required vary and are not guaranteed.

Indication / treatment area _____

LED colour/wavelength, time and settings _____

Eye protection used _____

E. Lash lift / Korean lash lift / lash tint Client initials: _____

☐ Chemical solutions and/or tint will be used close to the eyes. A patch test reduces but does not eliminate the risk of a reaction.

☐ Possible effects include stinging, watering, redness, swelling, irritation, allergic reaction, chemical burn, dry or brittle lashes, lash breakage, uneven lift, over-processing, under-processing or unsatisfactory colour.

☐ I have disclosed eye infection, inflammation, recent eye surgery, severe dry eye, lash loss, allergies and use of contact lenses. I will remove contact lenses if directed.

☐ I will immediately tell the clinician about burning, pain or eye symptoms. The treatment will be stopped and the area flushed if necessary.

☐ Results depend on natural lash condition and growth cycle and cannot be guaranteed.

Patch test date/result or reason not performed _____

Products, shades, lot/batch and expiry _____

Processing times _____

F. Brow lamination / brow tint Client initials: _____

☐ Chemical solutions and/or tint will contact the brow hair and surrounding skin. A patch test reduces but does not eliminate the risk of a reaction.

☐ Possible effects include redness, itching, swelling, irritation, allergic reaction, chemical burn, dry or brittle hair, breakage, uneven result, over-processing, under-processing or unsatisfactory colour.

☐ I have disclosed skin conditions, broken skin, recent exfoliation/peels/retinoids, allergies and previous reactions in the brow area.

☐ I will immediately report burning or pain. Results depend on the natural brow condition and cannot be guaranteed.

Patch test date/result or reason not performed _____

Products, shades, lot/batch and expiry _____

Processing times _____

6. Client declaration and consent

I confirm that I have read and understood the sections relevant to my selected service, that the information I provided is accurate, and that I voluntarily consent to today's selected treatment.

Client name	_____
Client signature	_____
Date / time	_____

7. Clinician assessment and treatment authorisation

☐ Suitable to proceed	☐ Proceed with modification
☐ Postpone / decline	☐ Medical clearance required

Reason / modifications / precautions _____

Consultation and risks discussed _____

Aftercare supplied (document/version) _____

Review recommended _____

Additional treatment record notes _____

_____

_____

Clinician declaration

I confirm that I reviewed the client's responses, assessed suitability within my scope of practice, explained the selected procedure and material risks, answered questions, and obtained consent before commencing treatment.

Clinician	Adrienne Turner
Qualifications	Endorsed Enrolled Nurse; Beauty Therapist
Signature	_____
Date / time	_____

8. Consent confirmation for a later appointment

Use this section when the master form remains current. The client must still disclose changes and consent to the specific service on the day. Complete a new master form if health information, treatment type or circumstances materially change.

Date	Service / area	Changes disclosed?	Client initials	Clinician initials
		☐ No ☐ Yes		
		☐ No ☐ Yes		
		☐ No ☐ Yes		
		☐ No ☐ Yes		
		☐ No ☐ Yes		
		☐ No ☐ Yes		
		☐ No ☐ Yes		
		☐ No ☐ Yes		

Document control

Document	Master Client Consent Form
Clinic	Dermal Camouflage Clinic
Version	1.0 — August 2026
Review	Review at least annually and whenever services, products, legislation or clinical procedures change

This form supports, but does not replace, a service-specific consultation, suitability assessment, treatment record and written aftercare.