

Lash Extension and Lash Lift/Tint Consent Form

(Aesthetics)

Date:

Patient Information

- **Patient Name:**
- **Date of Birth:** Patient DOB

Consent Statement

I acknowledge that I have read and understand the information provided about this treatment/service. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction.

I agree to the terms and conditions described above

Signature

Patient Signature: (Sign below)

Date:

Medical Services provided by Primary Medical of KY, P.S.C., Elite Health Services, P.A., Co., Primary Medical of IN, P.C.



Signature Certificate

Document name: Lash Extension and Lash Lift/Tint Consent Form

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