fusion
Massage & Wellness

Name _____ Phone (_____) _____ DOB _____
*Cell phone provider: _____ (for text confirmations)
Address _____ City _____ State _____ Zip _____

Email _____ Would you like to receive monthly emails about discounts and specials? Yes ☐ No ☐

How did you hear about us (family/friend's name, internet search, etc.)? _____
(*If a certain friend told you about us, please list their name so they may receive their loyalty points!)
Occupation _____ Male _____ Female _____

Emergency Contact Name _____ Phone # (_____) _____

Have you ever had eyelash extensions applied before? *Yes ☐ No ☐
*If yes, please specify the last time you had extensions done and type of extensions: _____

Please check all the following that apply:

☐ Wear contact lenses	☐ Use eye drops	☐ Use daily eye medication
☐ Use mascara	☐ Use eye makeup remover	☐ Have had lashes permed
☐ Have had lashes tinted	☐ Issues with eye sensitivity	☐ Had Lasik eye surgery? Date: _____
☐ Issues with watery eyes	☐ Permanent eye make-up	☐ Use an eyelash curler
☐ Use any type of eyeliner	☐ Use saunas, steam rooms or hot tubs on a regular basis	

Are you currently seeing a physician for any medical or eye related issues? *Yes ☐ No ☐
*If yes, please explain: _____

If there is anything else related to your eyes that your technician may need to know, please list it here: _____
_____

Waiver of Liability: I understand there are risks associated with having artificial eyelashes applied to and/or removed from my existing eyelashes, and that notwithstanding the utmost of care in the application or removal of these products, there still exist risks associated with the procedure and product itself, which include, without limitation, eye irritation, eye pain, discomfort, and, in rare cases, blindness when improperly handled. As part of this procedure, I understand that a certain amount of eyelash adhesive material will be used to attach the artificial Longmi™ Lashes® to my existing eyelashes. Even though the professional may apply or remove my Longmi™ Lashes® properly, I understand adhesive material may become dislodge during or after the procedure, which may irritate my eyes or require further follow-up care, at my own expense to prevent damage to my eyes. I also understand that there is more than one technique for applying Longmi™ Lashes® to my eyelashes, and I will not attribute any liability to the professional as a result of this procedure or the use and care of these lashes. I also agree to defend, indemnify and

hold harmless Fusion Massage & Wellness from any and all claims, actions, expenses, damages and liabilities, including reasonable attorneys' fee which might be asserted against them as a result of having this procedure performed.

Care and Maintenance: I agree to follow the care and maintenance instructions provided by Fusion Massage & Wellness for the use and care of my eyelash extensions, and that if any follow up care is required due to my own mistake or negligence, or failure to follow these instructions, this will be at my own expense and risk. I understand that I do any of the following, it may result in damage my Longmi™ Lashes® or may case my lashes to fall off prematurely. Knowing this I agree to follow these tips for best results as stated in the post care card given to me by my professional.

No Known Medical Conditions/Informed Consent: I have read and completed this form in its entirety and in truth. I acknowledge that I have been advised of the potential harmful or negative side effects (such as premature shedding of my eyelashes) that the lash extension procedure or removal may cause to those who have specific medical or skin conditions. I understand that the adhesives and adhesive remover are skin, eye and mucus membrane irritant and that in rare cases can cause an allergic reaction or hypersensitivity to occur. I understand that the procedure requires that I lay still for up to 2 hours or longer with my eyes shut, and that if I wear contacts, I must remove my contact lenses for the duration of the application procedure. I further state that I have no known medical conditions that might be aggravated by the procedure or any medical condition that would prevent me from complying with or heeding to the professional's instructions or warnings.

I agree that this Agreement is binding upon me, and my heirs, legal representatives and assigns. I represent that I am over 18 years of age and that I have the right to enter this agreement, or if I am under 18 years of age, I have had my parent or legal guardian consent to this agreement, and his or her relationship to me is as follows: _____. By his or her signature below, he or she ratifies and consents to this procedure under these terms.

Print Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____