

# Body Piercing by Bink, LLC

## CONSENT TO PIERCE AND RELEASE WAIVER OF ALL CLAIMS

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ \*Race: \_\_\_\_\_ \*Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Phone(s) #: \_\_\_\_\_

Email: \_\_\_\_\_

For my **check-up**, please contact me via:  **phone** **OR**  **email** (listed above)

\* Demographic information is required by the state and is kept confidential.

**I am NOT interested in receiving promotional emails**

I acknowledge by signing this release that I have been given the full opportunity to ask any and all questions which I might have about obtaining a piercing from BODY PIERCING BY BINK (hereafter called "Piercer") and that all of my questions have been answered to my full and total satisfaction. I specifically acknowledge that I have been advised of the matters set forth and agree as follows: **(please initial each statement on the line)**

\_\_\_\_\_ If I am pregnant or nursing I have informed and discussed this with my Piercer.

\_\_\_\_\_ If I suffer from any medical condition that may hinder successful healing of this piercing, I have informed and discussed this with my Piercer.

\_\_\_\_\_ I do not have any medical or skin conditions such as, but not limited to, MRSA, bleeding disorders, keloid, hypertrophic scarring, psoriasis, or open wounds or lesions at the site of the piercing.

\_\_\_\_\_ I have advised the Piercer of any and all allergies including metals, latex, soaps, and medications. I acknowledge it is not possible for the Piercer to determine whether I might have an allergic reaction to the piercing or processes involved in the piercing and I further acknowledge that such a reaction is possible.

\_\_\_\_\_ I have truthfully represented to the Piercer that I am over the age of 18 years **OR** have provided notarized parental consent.

\_\_\_\_\_ I am not under the influence of drugs or alcohol. To my knowledge, I do not have any physical, mental, or medical impairment or disability which might affect my well-being as a direct or indirect result of my decision to have a piercing done at this time.

\_\_\_\_\_ I acknowledge that obtaining a piercing is my choice alone and will result in a permanent change to my appearance and that the skin involved in the piercing may not be restored to pre-piercing condition. I understand that even with optimal aftercare the piercing may reject or have to be removed. If I choose to seek piercing advice from a physician, Body Piercing by Bink, LLC is not responsible for expenses acquired.

\_\_\_\_\_ I acknowledge that infection and/or irritation can result from environmental irritants and/or trauma. I agree to follow all instructions concerning the care of my piercing during the stated and written healing period.

\_\_\_\_\_ I understand I will be pierced using sterile instruments and jewelry, using aseptic technique compliant with Florida Statute 381.0075 & Rule Chapter 64E-19. The jewelry used for piercing is **medical implant quality**.

\_\_\_\_\_ Body Piercing by Bink provides free lifetime aftercare advice but it is MY responsibility to monitor the piercing **daily** and bring any issues or concerns to the attention of my piercer **immediately**.

\_\_\_\_\_ I understand that filming and photography is **NOT** allowed during any procedure.

Therefore, I request the Piercer to perform the following piercing. I understand this type of piercing usually takes the stated amount of time **or longer** to heal. I agree to release and forever discharge and hold harmless the Piercer and all employees from any and all claims, damages, or legal actions arising or connected in any way with my piercing, or the procedure and conduct used in my piercing.

**Emergency Contact:** \_\_\_\_\_

**OR**  
 **911**

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_

**OR**  
 Dept. of Health  
 Walk-in Clinic  
 University Health Center

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

How did you hear about the shop? \_\_\_\_\_

Have you eaten within the past 4 hours. \_\_\_\_\_ OR Glucose \_\_\_\_\_

Do you have to take prophylactic antibiotics before dental procedures? \_\_\_\_\_ (oral piercing only)

Do you have any allergies including (but not limited to) Iodine, Chloroxylenol, Bacitracin, BZK, Latex, or other topical chemicals? \_\_\_\_\_

Date:	Location:	Healing:	Jewelry:

I have received both verbal and written education and information regarding my piercing. I understand that I may have a copy of this statement if I choose to request it.

I certify under Penalty of Perjury that all included information is true and correct.

Client's Signature: \_\_\_\_\_

Piercer's Signature: \_\_\_\_\_

Piercer's Printed Name: \_\_\_\_\_