READ CAREFULLY – CONSENT TO TREATMENT Ultrasound Cavitation Treatment Agreement

Name: _____ Email Address: _____

DOB: _____ Address: _____

City: _____State:_____ Zip: _____ Phone: (work) _____
(home) _____ (cell) _____

Emergency Contact: (name) _____

(phone) _____Additional phone_____

Ultrasound Cavitation Treatments: Check all that apply

____ Abdomen

____ Upper Front Legs "Saddle Bags" or "Thighs"

____ Back of Upper Legs (Hamstring Area)

____ Inner Thigh

____ Arms (triceps side)

____ Back

____ Buttocks

____ Calf

____ Flanks "Love Handles"

____ Neck and Face rejuvenation

Fees. All costs are payable in-full prior to initial treatment and are non-refundable. Payments must be completed for entire package price (1, 3, 6, 9 or 12 sessions) on first visit to receive package discount. Packages once purchased and treatment initiated are non-refundable. In certain cases, a payment plan will be made available to you.

Payment plan: First Payment due: _____

Second payment due: _____

Medical Background.

Check if you answer YES to any of these questions:

___ Are you pregnant or nursing?

___ Do you have hemophilia?

___ Are you epileptic?

___ Do you have thrombosis and/or thrombophlebitis?

___ Do you have any kind of tumor or cancer?

___ Do you have melanoma?

___ Do you have any cardiac or vascular disease or condition?

___ Have you undergone a transplant?

___ Do you have any acute inflammation?

___ Do you have a Neurological disorder?

___ Do you have a wound that has not healed?

___ Are you being treated with anticoagulants?

___ Do you have current or any history of internal bleeding?

___ Do you have any keloid?

___ Do you have a pacemaker or other electronic device?

___ Do you have any kind of heart trouble?

___ Do you have any plastic or bone cement or any large implants?

Do you have any current infection? metal implant? WHERE?

_____

Do you have any infectious disease or tuberculosis? ___

Have you had any abdomen operations? ___

Do you have advanced untreated diabetes? ___

Do you have any abnormally high or low blood pressure? ___

Do you have a communicable disease? ___

Do you have high levels of Triglycerides (hereditary)? ___

Do you have any type of heart, kidney, liver diseases? ___

Are you allergic to zinc or nickel? disease? ____

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS YOU MAY NOT BE ELIGIBLE FOR THE TREATMENT. Explain any "Yes" answers:

_____

_____

Are you presently taking any medications?

List: _____

Are you allergic to any foods or medication? List:

_____

Please explain any other current medical conditions.

_____

Are you taking any vitamins/supplements?:

_____

Are you presently under a physician's care? What for?

_____

Are you taking recreational drugs?

_____

Please list your family or primary treating physician name and phone number:

_____ _____

Client/Patient (Printed) _____ Date Signed _____

Client Signature _____

Accepted by Technician _____

READ CAREFULLY – CONSENT TO TREATMENT Disclosure. This treatment is a process and subsequent visits may be necessary in order to achieve the desired results. Subsequent visits are subject to additional charges per visit which depend on the amount of work needed. Actual results vary from person to person and Atlanta Body Retreat, LLC does not guarantee any specific result. However, most people on average lose between 3-4 inches cumulatively. In some cases, many more!

The Ultrasound Cavitation treatment carries with it possible health complications and consequences, which include but might not be limited to the risk of kidney failure, liver failure, pacemaker failure, birth defect, miscarriage, thyroid damage, damage to the ovaries, lactation complications, hyper-triglyceridemic, hypercholesterolemia, pancreatitis, infection, scarring and/or allergic reaction to any products used, excessive thirst, dehydration, nausea.

The Ultrasound Cavitation treatment includes, but is not limited to, the use of high-power low-frequency ultrasound cavitation which uses 40KHz frequency ultrasound to penetrate the skin and assist with the breakdown of fat cells by creating micro-bubbles that increase the pressure around the adipocyte and force it to implode, thus breaking down adipocyte's cell membrane. This is an FDA approved machine and treatment, with little to no downtime but you may see bruising which will eventually go away.

After Care. After care instructions must be followed explicitly, whether given in writing or orally. Failure to follow after care instructions may compromise the final results of the treatment.

Before, During and After Pictures: Before, during and after pictures or videos may be taken to document the treatment. These pictures or videos become Atlanta Body Retreat's sole property and may only be used for its legitimate business purposes.

Release. I recognize that there are certain inherent risks associated with the above-described treatment and I assume full responsibility for personal injury to myself. In exchange for such treatment, I hereby fully release and forever discharge Atlanta Body Retreat (including its officers, members, owners, employees and agents) from any and all damages, costs, expenses, liabilities, causes of action, claims and demands, of whatever character, in law or in equity, whether known or unknown, direct or indirect, asserted or unasserted, and whether or not on account of myself, Atlanta Body Retreat or other third parties, or in any way arising out of the above described treatment I have requested Atlanta Body Retreat perform.

It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to the treatment or services provided by Atlanta Body Retreat including any spouse or heirs of the client/patient and any children, whether born or unborn. Any legal or equitable claim that may arise from participation in the treatment shall be resolved under Georgia law. I agree to indemnify, hold harmless and defend Atlanta Body Retreat (including its officers, members, owners, employees and agents) against all third-party claims, causes of action, damages, judgments, costs or expenses, including attorneys' fees and other litigation costs, which may in any way arise from the above described treatment I have requested Atlanta Body Retreat to perform.

Arbitration. It is understood that any dispute arising as to malpractice of the Ultrasound Cavitation treatment shall be decided by a neutral arbitrator. Any arbitration proceeding will be governed by Georgia's arbitration statute, the fees for the arbitrator will be split pro-rata among the parties and each party will be responsible for their own attorneys' fees and costs. Any action to collect fees from the client/patient for the treatments performed may be brought in any court located in Georgia and the prevailing party in such collection action shall be entitled to recover its reasonable attorneys' fees and costs.

Filing of any action in any court to collect any fee from the client/patient shall not waive the right to compel arbitration of any malpractice claim. By signing this agreement, I confirm that I am over the age of 18, I understand that the Ultrasound Cavitation procedure has possible adverse consequences and that the procedure is for cosmetic purposes only. I certify that I have read the above paragraphs; fully understand this consent and procedure form and herby consent to the indicated procedure(s). This means that I accept full responsibility for these and/or any other complications which may arise or result during or following the Ultrasound Cavitation procedure which is to be performed at my request according to this agreement and I hereby agree to arbitration of any malpractice claim.

I further understand that by signing this agreement, I surrender certain legal rights.

Client/Patient (Printed) _____Date Signed _____
Client Signature _____

Accepted by Technician _____Date Signed _____

READ CAREFULLY – CONSENT TO TREATMENT Financial Policy: Thank you for selecting Atlanta Body Retreat for your cosmetic needs. We are honored to be of service to you. This is to inform you of our billing requirements and financial policy. Please be advised that payment for all services is due at the time services are rendered. We require full payment for the visit prior to being seen by our cavitation technician. We accept Check, Credit Card, Debit and Cash. All forms of payment are immediately run through an electronic processing system and immediately deposited into electronic transfer system. In the event this account is referred to an agency for collections or if an electronic check is returned you agree to be responsible for all returned fees including any collections costs, collection's agency and/or attorney's fees used for collection.

Client/Patient (Printed) _____

Date Signed _____

Client Signature _____

Accepted by Technician _____

Date Signed _____