Zerona6 LipoLaser/ Laser Assisted Liposuction
Consent & Assumption of Risk

Name:_____Date:_____

I, the undersigned patient, while attending a course of care at Spine Sync for FDA cleared laser-assisted liposuction treatment, fully understand the protocols, methods, rationale and limitations of the treatment, and do so at my own risk. I understand that there are no promises made for specific anthropometric outcomes, since there are many components that contribute to the success of the treatment that are out of the control of Spine Sync. I fully release, discharge and waive any claims that I may have, now or in the future, against Spine Sync, it's owners, employees, volunteers, agents, independent contractors, or any other personnel in any way assisting at Spine Sync even if claims are based on carelessness or negligence of the released party or anyone else. I assert that Spine Sync is not be liable for any damages arising from personal injuries sustained in, on or about the premises of said facility, and do hereby fully and forever release and discharge the Spine Sync owners, and employees from and damages arising from action or cause of action present of future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of Spine Sync's facilities and equipment.

Signature:_____

☐ Please provide a copy of this signed document for my records

SPINE SYNC 2300 Artesia Blvd #B Redondo Beach, CA 90278
www.spinesync.org 310-663-8602