Ko' Kontou Beauty Bar Body Contouring Intake and Consent Form

New Client History

Name: _____ Date: _____

Birth Date: _____

Sex: M/F

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Occupation: _____

How did you hear about us: * (If someone referred you here, please name them so that we may thank that person) _____?

Friend Referral _____

Social Media (Please indicate which version you used to find out about our office)
Facebook _____Instagram _____Website _____ Other (please specify below)

_____

What is your main area(s) of focus/your problem area(s)_____?

Medical History

Do you have any chronic medical conditions which we should know about? Yes/No
If so, please list: _____

Do you have any allergies to latex, medications, herbal or natural supplements? Yes/No
If so, please list: _____

Do you have, or have you had, any changes in medical history recently? Yes/No

Explain: _____

Do you have Hearing aids, Pacemaker or Hormone Pellets (where) or metal/medical devices implanted? Yes/No Explain: _____

Do you have type 1 or 2 Diabetes? Yes/No

List all current Medications including
Vitamins_____

Do you have or have you had Cancer in the last 12 months? Yes/No

If yes, are you currently on chemotherapy? Yes/No

Do you have a Thyroid Problem? Yes/No

Do you have High Blood Pressure or a Cardiovascular condition? Yes/No

Women only, are you currently pregnant or nursing? Yes/No

Please give us your current Weight_____ Height_____

Circle which applies to you: Epilepsy, Infections, Tumors, Skin Diseases,
Loss of Normal Skin Sensation, Thrombosis/Phlebitis, Autoimmune Disease,
Neck/Back Problems, Gallbladder Removed, History of Gallstones, History of Liver Problems

Are you currently dieting?
Explain_____

History of Colon problems including protruding/distended belly? Yes/No

Explain: _____

Have you had any surgeries? (Butt injections and implants are not permissible for this procedure)
_____

Typical daily food and drink intake

Water: How Many Glasses_____
Coffee: How often _____
Alcohol: How Much_____
Fast Food: How often_____
Soda or Carbonation: How often_____

Tobacco Use: Yes/No Recreational Drugs (narcotics) _____

Stress Level: Moderate /Average /Demanding

I, (print name) _____, consent to allow (body service technician) Ko' Kontou Beauty Bar to consult with & evaluate me to determine if I am a suitable candidate for the Non-surgical Body Contouring services. I understand that photographs and measurements will be taken and kept in my file.

I agree that these forms have been completed truthfully and to the best of my knowledge/abilities.

_____ _____
Client Signature Date

Consent Form

Body sculpting increases flow of both the lymphatic and circulatory systems, and it also helps with cleaning of the tissues. The main use of body sculpting treatment is inch loss, diminishing of cellulite, and tightening of the skin.

Benefits: Lose 1-3 inches per treatment with state-of-the-art equipment. Benefits are often immediate but may be delayed in some people.

For Best Results: A series of 9-12 body sculpting treatments are recommended per each area, but some individuals may require more treatments to achieve maximum results. There should be at least 1-2 days between each treatment. This is not a weight loss treatment, but an inch loss. The inches will only return if the client goes back to their old habits. Eating the right types of food, proper exercise, and drinking eight glasses of water per day are always recommended. For best results, it is recommended that you exercise within 4-6 hours of treatment and avoid sugar and alcohol for 24 hours after each treatment.

Precautions: Body sculpting treatments are not recommended if you are pregnant, breast feeding, have a lymphatic disorder, acute illness, metal implants, pacemakers, or are currently being treated for active cancer.

Waiver: I understand that I am using body sculpting treatments such as: wood therapy, sauna detox, laser lipo, body cavitation, radio frequency skin tightening, vacuum butt lift, at my own risk. Should I sustain an injury while using the equipment or during any service, I agree to not hold Ko' Kontou Beauty Bar responsible.

Acknowledgement: I understand and acknowledge that payments for the above services are non-refundable. By my signature below, I certify that I have read and understand the contents of this Consent Form. I further agree to provide Ko' Kontou Beauty Bar 24-hour notice of a cancellation or change in appointment time, or I will forfeit a treatment off my package since treatments are by appointment only. There are no refunds if I am responding to treatment and decide to stop treatments. Should Ko' Kontou Beauty Bar wish to use any photos of my progress, I agree to use of those photos with the elimination of showing my face.

_____ _____

Client Signature Date

Terms of Acceptance/Informed Consent

Please read carefully and understand the contents of this form. Ask us if you not understand.

When a client seeks Body Contouring services it is essential that both the client and service provider are seeking and working for the same goals. We expect our clients to take full responsibility for their decisions to participate in any of the services/programs offered by this office. We do not identify, diagnose, or treat ANY condition or disease. We have only one goal: TO OPTIMIZE YOUR BODY'S ABILITY TO FUNCTION NORMALLY AND OPTIMIZE YOUR FAT-BURNING POTENTIAL. By reducing bio-stress levels, we allow the body's inborn self-correcting mechanism to work at maximum efficiency to restore, maintain and promote wellness.

We do not identify or diagnose any condition(s) or disease(s). We offer no treatment for any condition(s) or disease(s). We promise no cure from any disease(s) or condition(s). Instead, we facilitate your body's own self-correcting mechanism.

It is essential that you speak to your doctor prior to making any decisions about altering any medical regimen you are currently following, changing your diet, taking supplements, or going on an exercise and/or weight loss program. Getting your doctor's approval prior to starting any service/program at our office is critical and solely your responsibility. Should any health condition arise while you are a client with us, we recommend that you immediately see the appropriate health care provider.

Any options or suggestions that are rendered by the staff and/or head personnel should NEVER be construed as medical advice but merely as opinions. If you like medical advice, please see your medical doctor. We will not deal with any medical condition.

With your signature below, you understand and voluntarily accept these risks and agree that neither Ko' Kontou Beauty Bar, its owner or staff, or any of its partners will be liable for any injury to you, including, but not limited to, personal bodily injury, death, mental injury, economic loss or any damage to you, your spouse, or relatives resulting from any act of Ko' Kontou Beauty Bar and its staff or anyone else using the facilities and that you acknowledge the inherent risks of the positions, movement, dietary/nutritional programs offered to and done to you by Ko' Kontou Beauty Bar, with respect to your current or past condition(s). If there is any dispute between you and Ko' Kontou Beauty Bar, and/or any of its staff or owner, both parties agree to submit it to binding arbitration. We both agree to have a neutral arbitrator preside over any such dispute, not a judge or jury.

I, the undersigned, understand and accept the conditions as laid out in the "Terms of Acceptance" above.

_____ _____

Client Signature Date

Office Acceptance by: _____

Service Agreement

The following provisions apply to the services to be performed for _____.
Client Name

(1) SERVICES TO BE PROVIDED

The Office provides ultrasonic cavitation, laser lipo, vacuum butt lifts, wood therapy, detox sauna, and radio frequency treatments.

(2) PAYMENT

Payment in full is to be made electronically.

(3) CLIENT COOPERATION

This Agreement contemplates full Client cooperation in the course of services agreed upon. This cooperation includes Client's agreement to remain active in the recommended program for all body contouring visits. The Client recognizes that compliance with recommended services and service schedule is important, and the Client agrees to follow the service plan and the course of treatment agreed upon. The Client understands that lack of cooperation, failure to keep appointments and engaging activities identified by the office as potentially counterproductive to the body may necessitate additional treatments to those otherwise provided for this Agreement. Our office policy requires 24-hour advance notice for appointment cancellation. Failure to do so may result in deduction of pre-paid visits. _____ (Initials)

(4) TERMINATION

Subject to the provisions of paragraphs 5 and 6 of this Agreement, the Client may discontinue care and terminate this Agreement at any time by written notice to that effect delivered in person, or by mail, to the office. Such "notice of termination" shall discharge the office from all further obligations and/or duty to render care to the client. The office reserves the right to terminate this Agreement in its sole discretion notwithstanding any other terms or provisions of this Agreement. ` _____ (Initials)

(5) NO REFUNDS IN THE EVENT CLIENT TERMINATES AGREEMENT

To encourage commitment and follow-through, we offer no refunds. No refunds will be made on body contour treatments. There will be no exceptions. The prepaid program cannot be altered, shared, or transferred, nor can it be combined with any other program. _____ (Initials)

(6) NO GUARANTEE OF RESULTS

Client recognizes that neither Office personnel nor this Agreement provides a guarantee of results. The Office makes no guarantee of the extent or longevity of improvement to be expected. This Agreement deals solely with the services to be rendered and the fees to be paid for the care as provided. The Client's payment obligation is not contingent upon the outcome of services. Client's results can be hindered and/or suppressed by the consumption of the following, but are not limited to, alcohol, processed foods including, but not limited to, sugar-based foods and drinks, fatty foods, fast foods, etc. It is recommended to consult your physician for dietary modification clearance if you have any questions or concerns. _____ (Initials)

(7) TIME LIMITATION FOR SERVICES

Client understands that unused visits will expire if not used within 120 days from the date Client starts the treatment unless the Office has been provided with advance notice in writing of leave of absence or other cause of delay. After 24 weeks, all outstanding services/visits will be void. _____ (Initials)

(8) RELEASE OF LIABILITY

Client agrees to indemnify, hold harmless and release Ko' Kontou Beauty Bar, its agents, employees, officers, directors, representatives, assigns, members, affiliated organizations, and insurers, and others acting on the Company's behalf, of all claims, demands, causes of action, and legal liability, whether the same beknown or unknown, anticipated or unanticipated, and further agrees that except in the events of the Company's gross negligence or willful and wanton misconduct, no claims, demands, legal actions and causes of action, shall be made against the Company for any economic and non-economic losses of any kind._____ (Initials)

(9) YOUR RESPONSIBILITIES

1. Keep your appointments. We require 24-hour advance notice to reschedule/cancel an appointment.
2. Follow your program as closely as possible. Report any deviations to the Office staff so that we can help you get back on track.
3. If you have any challenges whatsoever, please share them with us immediately. Remember, it is in both our interests for you to succeed in achieving your goals.
4. If you have any medical conditions, please share this program with your physician immediately.

Ko' Kontou Beauty Bar is not a medical facility and does not make medical decisions.

____(Initials)

(10) GOVERNING LAW

This Agreement shall be governed, construed, and interpreted by, through and under the Laws of the State of Delaware.

(11) COMPLETE AGREEMENT

This Agreement constitutes the complete agreement and understanding between Client and Office and will not be changed or modified in any way unless agreed to by both parties in writing. _____(Initials)

PLEASE READ THIS DOCUMENT CAREFULLY.
DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ IT COMPLETELY.

THE CLIENT HAS FULLY READ THIS AGREEMENT AND ANY SUPPLEMENT HERETO AND UNDERSTANDS AND AGREES TO ABIDE BY ALL OF THE TERMS HEREOF.

_____ Client Printed Name

_____ Client Signature

OFFICE ACCEPTANCE:
BY: _____

_____ Date

Client Measurement Log

Date: _____ Waist: High ____ Mid ____ Low ____ Hips: ____ Butt: ____ Arms: ____ Thighs: ____

Date: _____ Waist: High ____ Mid ____ Low ____ Hips: ____ Butt: ____ Arms: ____ Thighs: ____

Date: _____ Waist: High ____ Mid ____ Low ____ Hips: ____ Butt: ____ Arms: ____ Thighs: ____

Date: _____ Waist: High ____ Mid ____ Low ____ Hips: ____ Butt: ____ Arms: ____ Thighs: ____

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Date: _____ Waist: High ____ Mid ____ Low ____ Hips: ____ Butt: ____ Arms: ____ Thighs: ____

Notes

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MIC and Vitamin B12 Weight Management Injections Consent

What is MIC? This is a proportional blend of several ingredients, each of which help with energy levels and weight loss form a different angle. Each of the ingredients has a long track record of safety. By combining the ingredients in this proportional manner, you will receive a synergy of the benefits of each.

Here's what the MIC injection contains:

- The amino acid Methionine which helps break down fat and increases energy.
- The vitamin Inositol which is vital for the metabolism of fat and cholesterol.
- Choline which contributes to cardiovascular health.
- Vit BI2 is also added to the cocktail as an energy booster

Can I take the injection long with other weight loss medicines?
Yes. Most people find that MIC injections along with a low glycemic diet consisting of zero sugar and low carbohydrates in conjunction with regular exercise are all needed to achieve maximal weight loss and energy levels. However, if you are looking to turbo-charge your weight loss, it is safe for use with any of the other weight loss medications like the appetite suppressant.

Are there any side effects?
No serious side effects have been reported. Tingling or a slight burn at the injection site is sometimes reported. Patients often describe this sensation as feeling the shot starting to work. As with any injection, there is a tiny chance of bleeding or infection at the injection site. Some people report slightly cloudy thinking for a few days as the brain is cleared of chronic toxins. Rare, but potential. Side effects may include stomach upset, or urinary problems due to detox strain on the kidneys. Detox depression, fatigue, or diarrhea. Finally, some patients reported an unpleasant odor. Very rarely patients may experience an allergic reaction to the injections. Call your healthcare provider immediately, or report to urgent care, if you experience any signs of an allergic reaction: wheezing; breathlessness; chest tightness; fever; itching; bad cough; or swelling of face, lips, tongue, or throat; altered consciousness; or if you experience chest pain or pressure or fast heartbeat, severe dizziness or passing out, nervousness and excitability, or severe headache.

How often should I get an injection and for how long should I continue them?
MIC injections are given weekly. Receiving them any more often will not increase your results. Most authorities recommend a 3-month course of injections for optimal results. It is completely safe to continue the injections as long as benefits continue.

Does my medical condition prevent me from taking the MIC injection?
MIC injections are safe in virtually all medical conditions. They can also help most chronic conditions such as High Blood Pressure, Diabetes, High Cholesterol, Heart Failure, Fibromyalgia, Chronic Fatigue, Obesity, NASH, Fatty liver, etc. Being as safe as or safer than most prescription medications, MIC injections are safe at virtually any age.

I hereby give my voluntary consent for the above treatment and release **Ko' Kontou Beauty Bar** medical staff, and specific technician from liability associated with the MIC cocktail injections. I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This consent form shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree if I should I have any questions or concerns regarding my treatment/ results I will notify this office at **800-565-4062** immediately so that timely follow-up and intervention can be provided.

When purchasing the MIC lipotropic injection package, you will need to do it on a weekly basis (once a week), if 1 week is missed it will not be replaceable. The weeks will start from your first visit. It is crucial that you maintain a healthy diet and exercise regularly in order to see results.

You have purchased the package of ___ shots, for $____ starting on date _____

Client Name (Print)	Client Signature	DOB	Date

Witness Name (Print)	Witness Signature	Date

Ko' Kontou Beauty Bar

This procedure maybe considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition which it has been prescribed. This therapy has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite probably improve the condition for which you are under treatment and in your overall health.

Based on the risks and potential benefits of the current medically indicated treatment(s) and of this proposed treatment, I have elected to forego or supplement the indicated treatment(s) and receive this proposed treatment from the doctors and other health professionals at **Ko' Kontou Beauty Bar** as is appropriate and necessary for my care.

I further understand and agree to adhere to the treatment schedule and attend the follow-up visitations set by my medical provider to permit observation and study of my progress. I understand that I may suspend or terminate my treatment at any time by informing my medical provider. I assume all liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure. The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer- reviewed publications and therefore may be considered medically unnecessary or not currently indicated.

I hereby place myself under your care for intravenous vitamin therapy. I also verify that all information presented to the medical provider in my medical history is true to the best of my knowledge. I am not misrepresenting myself and I place myself under your care for the sole purpose of treatment for these conditions.

I hereby acknowledge that I understand that my insurance coverage, including Medicare, may not pay for this noncovered service, and that all services ancillary to this treatment may be also non-covered services and non-reimbursable. I agree to be responsible for payment at the time of service for all non-covered services.

_____

Print Client Name

Client Signature Date

Name: _____ DOB: _____ Date: _____

Informed Consent for Intravenous (IV) Therapy

This document is intended to serve as confirmation of informed consent for IV therapy as ordered by Ko' Kontou Beauty Bar LLC.

___ I have informed the nurse of any known allergies to drugs or other substances that may be included in the ingredients of my solutions, or of any past reactions to aesthetics.

___ I have informed the nurse of all current medications and supplements.

I understand that I have the right to be informed during the procedure and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids).

I understand that risks, benefits, and alternatives to IVs may include but are not limited to:

1. The Risks and potential side effects:
    - Discomfort, bruising, and pain at the site of injection.
    - Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    - Severe reaction, anaphylaxis, cardiac arrest, or death.
2. The Benefits:
    - Injectables are not affected by stomach or intestinal disease.
    - Total amount of infusion enters the bloodstream and is available to the tissues
    - Higher doses of nutrients can be given by vein than by mouth without intestinal irritation that can accompany doses given by mouth.
3. Alternatives to intravenous vitamin therapy are oral supplementation and/or dietary and lifestyle changes.

I am aware that other unforeseeable complications could occur. I do expect the nurse to exercise judgement during the course of treatment with regards to my procedure.

I understand the risks and benefits of the procedure and have had the opportunity to have all my questions answered.

I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV therapy with any different or further procedure, which in the opinion of **Ko' Kontou Beauty Bar LLC** or other(s) associated with this business, may be indicated. I understand the information provided on this form and agree to the foregoing.

I understand that there is no implied or stated guarantee of success or effectiveness of any treatment. The procedures set forth above has been adequately explained to me by the nurse. I understand that I am free to withdraw my consent and to discontinue participation in the treatment at any time.

I understand that, except in emergencies, I must give 24 hours' notice of intent to cancel or reschedule my appointment.

I understand that I will incur the full fee for treatment, regardless of amount used due to wasted materials. My signature below confirms that:

1. I have received all the information and explanation I desire concerning the procedure.

2. I authorize and consent to the performance of the procedure(s).

Date: _____ Patient Name(Printed):_____

Patient Signature: _____