PAGANI T-SHOCK™ | CLIENT INTERVIEW FORM

DATE

PLEASE TELL US ABOUT YOURSELF...

BASIC INFORMATION

LAST NAME | FIRST NAME | MIDDLE | SUFFIX

STREET | CITY | STATE | ZIP

MOBILE NUMBER | EMAIL | DATE OF BIRTH (/ /) | ☐ MALE ☐ FEMALE GENDER

HEIGHT | WEIGHT | GOAL WEIGHT

ANY ISSUES YOU WOULD LIKE TO SHARE

EXERCISE Specify frequency and duration for each activity.

- ☐ Cardio
- ☐ Yoga
- ☐ Pilates
- ☐ Weight training
- ☐ Other

DIET

Are you on a specific diet? ☐ Yes ☐ No If yes, please elaborate

How many ounces of water do you consume in a day?

☐ Under 32 ☐ 32 – 64 ☐ 64 - 96 ☐ 96+

Average Daily Caloric Consumption

☐ Under 1,500 ☐ Under 2,000 ☐ Under 2,500 ☐ 2,500+

Alcohol Consumption

☐ Light ☐ Moderate ☐ Heavy Frequency: _____ times per week

WHAT ARE YOUR TREATMENT GOALS?

Check any item you'd like to address.

FACE

- ☐ Reverse signs of aging
- ☐ Reduce wrinkles
- ☐ Improve skin tone
- ☐ Better definition
- ☐ Lift cheeks

NECK

- ☐ Turkey neck/sagging skin
- ☐ Reduce wrinkles
- ☐ Tighten double chin

DECOLETTE

- ☐ Reduce wrinkles
- ☐ Crepey skin

Please elaborate on areas of concern: _____

TONING [ARMS | LEGS | BACK | ABDOMEN | CHEST | HIPS] Circle areas of concern.

Specify problem areas of the body for each item.

- ☐ Crepey skin _____
- ☐ Wrinkles _____
- ☐ Hanging skin _____
- ☐ Loose skin _____

FAT REDUCTION Check any areas that apply.

- ☐ Arms
- ☐ Legs
- ☐ Abdomen
- ☐ Hips (love handles)
- ☐ Thighs
- ☐ Calves
- ☐ Gluteus
- ☐ Back

CELLULITE Check any areas that apply.

- ☐ Arms
- ☐ Thighs (Front ☐ Side ☐ Back ☐)
- ☐ Gluteus

DEFINITION | CONTOUR Check any areas that apply.

- ☐ Arms
- ☐ Chest
- ☐ Hips/Waist
- ☐ Abdomen
- ☐ Legs
- ☐ Back
- ☐ Gluteus

MUSCLE RELAX Check any areas that apply.

- ☐ Neck
- ☐ Arms (Left ☐ Right ☐)
- ☐ Legs (Left ☐ Right ☐ Thigh ☐ Calf ☐ Hamstring ☐)
- ☐ Back

OFFICE USE ONLY | ADICELL THERMOGRAPHIC FILM INTERPRETATION

Presence of hardened fat on abdomen

- ☐ Light
- ☐ Moderate
- ☐ Severe

Cellulite analysis (list locations)

- ☐ Edemous _____
- ☐ Fibrotic _____
- ☐ Sclerotic _____

Finnigan CHIROPRACTIC

CONSENT, RELEASE AND INDEMNITY AGREEMENT

The Cryo T-Shock safely and effectively uses thermal shock to naturally destroy fat cells without any damage to the skin. The Cryo T-Shock breaks down fat cells, which your body naturally flushes out through the bloodstream and the lymphatic system in days to weeks following the treatment. Cryo T-Shock also helps reduce the appearance of fine lines and wrinkles by stimulating collagen and elastin production while tightening muscles. The Cryo T-Shock is also beneficial for facial toning and lifting. Protocols will be discussed and or adjusted during consultation based on recommendations and client needs.

I understand that the results of Cryo T-Shock fat and/or cellulite reduction treatment (hereinafter referred to as "T-Shock Treatment") may vary depending on many individual factors, including but not limited to: medical history, prior treatments of the area being treated, skin type, compliance with pre- and post-care instructions and individual responses. I understand that for purposes of fat/cellulite reduction and/or skin toning I must maintain good dietary habits, maintain sufficient intake of water and participate in light physical activity as well as comply with all items, instructions and guidelines discussed during consultation prior to T-Shock Treatment.

I have been informed and understand that, following T-Shock Treatment, a vigorous workout for at least thirty minutes is required on the same day in order to facilitate lymphatic drainage.

I understand that any procedure involves risk. Known risks of T-Shock Treatment may include, but are not limited to: redness, swelling, irritation, skin reaction, or increased heart rate. Some individuals may experience delayed onset muscle soreness from treatments on the stomach due to unintentionally engaging the abdominals. Such muscle soreness ordinarily disappears later the same day. T-Shock Treatment may also entail risks not presently known or knowable.

Cryo T-Shock treatment should not be performed under the following conditions:

- Cryo T-Shock should not be applied over inflamed, infected, or swollen areas of the skin.
- Cryo T-Shock should not be applied over/near cancerous areas or on clients with active cancer or undergoing chemotherapy.
- Cryo T-Shock should not be used on clients who suffer from Kidney Disease.
- Cryo T-Shock should not be used on clients undergoing dialysis.
- Cryo T-Shock should not be used on clients who are pregnant.
- Cryo T-Shock should not be used on clients with varicose veins.
- Cryo T-Shock facial applications should not be used on clients who have had Botox treatments within 14 days or Filler treatments within 30 days.
- Cryo T-Shock should not be used on clients who suffer from severe diabetes where sensation has been lost in the skin.

By signing this agreement, I acknowledge and represent that, to the best of my knowledge, I do not have any of the foregoing conditions. I further acknowledge that I have been honest and forthright about my medical history and am healthy to receive T-Shock Treatment. I am not pregnant, nor do I have any other disease or condition that may be negatively impacted by T Shock Treatment.

By signing this agreement, I voluntarily agree to assume all risks of undergoing T-Shock Treatment, whether included among the known risks listed above, or whether such risks are presently known, unknown or unknowable, including risks related to contracting COVID-19. I accept sole responsibility for any injury, illness, damage, loss, claim, liability, or expense of any kind that I incur in connection with T-Shock Treatment. I agree to unconditionally and forever release, covenant not to sue, discharge, and hold harmless Finnigan Chiropractic Clinic officers, directors, employees, agents, affiliates, representatives, successors and assigns from any and all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating to T-Shock Treatment. I further agree that if any third-party brings legal or equitable claims that in any way relate to or arise from T-Shock Treatment performed on me against the Company and/or the Company's officers, directors, employees, agents, affiliates, representatives, successors and assigns (the "Indemnified Parties"), I will indemnify the Indemnified Parties for any liability or litigation costs incurred by Indemnified Parties as a result of such claims.

Photograph Release:

I give permission for photographs and other audio-visual and graphic materials to be used for marketing, education-promotion purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I will not be identified in the photos. Initial: Yes _____ No_____

Acknowledgement:

I understand each person has a different response to the T-Shock Treatment. The risks, benefits, and possible results have been explained to me. I have been provided the opportunity to ask questions and received satisfactory responses. I agree to have my photograph taken to document my results and will not be used for marketing unless agreed upon (see above). _____ Initial

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, _____, HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS TREATMENT, AND THAT I AM SIGNING IT VOLUNTARILY. SHOULD ANY PAIN OR DISCOMFORT OCCUR I WILL IMMEDIATELY NOTIFY THE STAFF. I UNDERSTAND THAT I MUST BE AT LEAST 18 YRS OLD TO PARTICIPATE IN THIS TREATMENT. I UNDERSTAND THAT ALL SALES ARE FINAL AND REFUNDS ARE NOT PERMITTED.

_____ Print Name

_____ Signature

_____ DATE:

Notice of Privacy Practices

Finnigan Chiropractic is committed to protecting the privacy and confidentiality of your protected health information as required by the Health Insurance Portability and Accountability Act (HIPAA).

Our Notice of Privacy Practices describes:

- How medical information about you may be used and disclosed
- Your rights regarding your health information
- How you can obtain access to this information

A copy of our current Notice of Privacy Practices is available upon request.

I acknowledge that I have been offered a copy of Finnigan Chiropractic's Notice of Privacy Practices.

Authorization to Release Information

I authorize Finnigan Chiropractic to discuss my care, appointments, billing, and/or protected health information with the following individuals:

Name	Relationship	Phone Number

I understand I may revoke my authorization to release information to the above-named individuals at any time.

☐ I do not authorize release of information to anyone other than myself.

Communication Preferences

Please select approved/preferred methods of communication:

☐ Phone Call ☐ Voicemail ☐ Text Message ☐ Email

I understand that standard text messaging and email may not always be secure forms of communication.

Patient Name _____

Parent/Guardian Name _____

Signature _____ Date _____

2026 No Show Policy

We value your time and are committed to providing personalized, high-quality care. To best serve all our patients, we have implemented the following No-Show Policy:

What Is a "No-Show"?
A **"no-show"** is defined as a missed appointment without prior notice to cancel or reschedule. This includes patients who arrive more than **15 minutes late** and cannot be accommodated due to scheduling constraints.

Policy Guidelines

- **Chiropractic Appointments**: A **$30 fee** may be charged to your account if an appointment is missed without any communication.
- **Body Sculpting Appointments**: A **$50 fee** may be charged to your account for missed appointments without 24 hours' advanced notice.
- **Massage Appointments**: A **$100 fee** may be charged to your account for missed appointments without 48 hours' advanced notice.
- **Repeated No Shows**: In addition to incurring the above listed fees, you may be required to pre-pay or leave a deposit for future appointments.

Why This Policy Is Important
Missed appointments disrupt continuity of care and limit appointment availability for other patients in need. Repeated no-shows may result in delayed treatment outcomes and could impact your overall health progress.

How to Cancel or Reschedule
For your convenience, we have several methods of communication including phone (360) 459-7800, text (360) 523-1261 and email frontdesk@finniganclinic.com. If it's outside of regular hours, please leave a voicemail or send an email. We understand that things happen and will take extenuating circumstances into consideration.

We appreciate your understanding and cooperation as we work together to support your health and wellness.

Patient Name: _____

Signature: _____ **Date:** _____