SNATCHED
RAPID FAT LOSS

SNATCHED CONSULTATION FORM

Appointment date _____ *Appointment time* _____ *Over the age of 18?* ☐ Yes ☐ No

CLIENT PERSONAL INFORMATION

Name _____ D.O.B. _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Occupation _____

Email _____

Emergency Contact _____ Phone _____

Height: _____ Weight: _____ BMI: _____

Do you exercise regularly? ☐ Yes ☐ No How often? _____

Do you follow a specific diet? ☐ Yes ☐ No Which diet? _____

Do you consume alcohol? ☐ Yes ☐ No How often? _____

Do you smoke? ☐ Yes ☐ No How often? _____

Do you drink water daily? ☐ Yes ☐ No How much? _____

Are you experiencing pain on any part of your body? _____

_____

What are your body concerns? _____

_____

What are your body goals? _____

_____

_____

FEMALE CLIENTS ONLY

Are you pregnant or nursing?

_____

When was the first day of your last menstrual cycle?

_____

GLP1 MEDICAL HISTORY

SNATCHED
RAPID FAT LOSS

MEDICAL HISTORY

Please check if you have any of the followings:

- ☐ Type 2 Diabetes
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disorder
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Pancreatitis
- ☐ Muscle spasms
- ☐ Gallstones

Other (please specify):_____

Please list all medications you are currently taking, including prescription, over-the-counter, and supplements:

_____

_____

_____

_____

HEALTH INFORMATION

Do you have a personal or family history of medullary thyroid carcinoma (MTC)?	☐ Yes	☐ No
Do you have Multiple Endocrine Neoplasia syndrome type 2?	☐ Yes	☐ No
Have you experienced pancreatitis in the past, or do you have a history of pancreatic issues?	☐ Yes	☐ No
Are you currently using insulin secretagogues or insulin?	☐ Yes	☐ No
Do you have a family history of diabetes or other obesity-related conditions?	☐ Yes	☐ No
Do you have a history of severe gastrointestinal disease ?	☐ Yes	☐ No
Have you been diagnosed with diabetic retinopathy?	☐ Yes	☐ No
Are you experiencing any symptoms of hypoglycemia or hyperglycemia?	☐ Yes	☐ No
Are you experiencing any symptoms of hypoglycemia or hyperglycemia?	☐ Yes	☐ No
	☐ Yes	☐ No
Do you have any known allergies to medications or any other substances?	☐ Yes	☐ No

If so (please specify):_____

GLP1 MEDICAL HISTORY

SNATCHED
RAPID FAT LOSS

HEALTH INFORMATION

Do you have any chronic medical condition? If so please list_____	☐ Yes	☐ No
Do you have or have you had cancer in the last 12 months?	☐ Yes	☐ No
Do you suffer from Heart disease?	☐ Yes	☐ No
Do you have any Liver or pancreatic conditions?	☐ Yes	☐ No
Are you pregnant or planning to become pregnant?	☐ Yes	☐ No
Are you currently breastfeeding or planning to breastfeed?	☐ Yes	☐ No
Are you currently undergoing treatment for any mental health conditions?	☐ Yes	☐ No

The most common side effects of Tirzepatide include nausea, diarrhea, decreased appetite, vomiting, constipation, indigestion, and stomach (abdominal) pain.
Stomach problems, sometimes severe, have been reported with Tirzepatide.
Tell your health care provider if you have stomach problems that are severe or will not go away.

Acknowledgement & Consent to proceed with treatments:

I have read, answered, and understood the above questions and I confirm that the above medical information that I have provided is true, full and an accurate statement of my current physical and medical status.

I confirm that I am at least 18 years of age and by signing this Consent Form, I agree to waive all liability towards SNATCHED Rapid Fat Loss or Dominion Aesthetic Technologies for any injury or damages incurred due to any misrepresentation of my medical history.

Client Signature: _____

Date: _____

GLP1 MEDICAL CONSENT

SNATCHED RAPID FAT LOSS

I acknowledge that I have been informed about the benefits, risks, and considerations associated with Tirzepatide treatment. I have had the opportunity to ask questions and have received satisfactory answers to my inquiries. I understand that Tirzepatide is offered as an injectable or sublingual prescription medicine used for adults with obesity (BMI ≥30) or overweight (BMI ≥27) who also have weight-related medical problems to aid in weight loss and weight management.

I acknowledge that Tirzepatide, while effective in promoting weight loss, carries potential risks and side effects, including but not limited to:

- Thyroid C-Cell Tumors: Tirzepatide has been associated with thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), particularly in patients with a personal or family history of MTC or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).
- Pancreatitis: There is a risk of pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, with Tirzepatide use, especially in patients with a history of pancreatitis.
- Hypoglycemia: Concomitant use of Tirzepatide with insulin secretagogues or insulin may increase the risk of hypoglycemia, including severe hypoglycemia.
- Hypersensitivity Reactions: Serious hypersensitivity reactions, such as anaphylaxis and angioedema, may occur with Tirzepatide treatment.
- Acute Kidney Injury: Tirzepatide can lead to dehydration and acute kidney injury, particularly in patients with renal impairment.
- Severe Gastrointestinal Adverse Reactions: Gastrointestinal adverse reactions, including nausea, vomiting, diarrhea, and abdominal pain, may occur with Tirzepatide use.
- Diabetic Retinopathy Complications: Rapid improvement in glucose control with Tirzepatide may temporarily worsen diabetic retinopathy.
- Acute Gallbladder Disease: Tirzepatide use has been associated with acute gallbladder disease.
- Other Common Adverse Reactions: Nausea, diarrhea, decreased appetite, constipation, and dyspepsia are among the most frequently reported adverse reactions with Tirzepatide.

I acknowledge that I should not take GLP-1 agonist medications if:

- I have a personal or family history of medullary thyroid carcinoma (MTC).
- I have Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).
- I have a history of severe pancreatitis.
- I have a documented history of serious hypersensitivity reactions to GLP-1 agonists.
- I have severe gastrointestinal disease, including severe gastroparesis.
- I have a history of acute gallbladder disease.
- I have other medical conditions or factors that contraindicate the use of GLP-1 agonist medications, as determined by my healthcare provider.

By signing below, I acknowledge that I have read and fully understand this consent form. I confirm that all items have been satisfactorily explained to me, and I have been given ample time to understand all its contents. I understand that by signing this form, I am consenting to Tirzepatide treatment and agree to adhere to the prescribed regimen.

Date: _____

Client Name (Printed) _____

Client Signature _____

SNATCHED RAPID FAT LOSS

SNATCHED TONE (EMS) MEDICAL HISTORY

SNATCHED TONE (EMS) is indicated for improvement of abdominal tone, strengthening of the abdominal muscles, development of firmer abdomen. Strengthening, toning and firming of buttocks, thighs, arms and calves.

Please answer whether you currently have or have had any of the following contraindications* :

Metal or electronic implants	☐ YES	☐ NO
Cardiac pacemakers, implanted defibrillators, implanted neurostimulators	☐ YES	☐ NO
Drug pumps	☐ YES	☐ NO
Pulmonary insufficiency or valve defect	☐ YES	☐ NO
Malignant tumor	☐ YES	☐ NO
Cardiovascular diseases	☐ YES	☐ NO
Disturbance of temperature or pain perception	☐ YES	☐ NO
Septic conditions and empyema	☐ YES	☐ NO
Acute inflammations	☐ YES	☐ NO
Systemic or local infection such as osteomyelitis and tuberculosis	☐ YES	☐ NO
Contagious skin disease	☐ YES	☐ NO
Elevated body temperature	☐ YES	☐ NO
Pregnancy, post-partum period, nursing and menstruation	☐ YES	☐ NO
Basedow's disease	☐ YES	☐ NO
Metallic IUD	☐ YES	☐ NO
Hemorrhagic conditions	☐ YES	☐ NO
Heart disorders	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO
Recent surgical procedures (muscle contraction may disrupt the healing)	☐ YES	☐ NO
Areas of the skin which lack normal sensation	☐ YES	☐ NO

Details for any of the above _____

Are you currently taking any medications, including oral, topical or transdermal? ☐ Yes ☐ No

Details _____

Do you have any allergies including a sensitivity or allergy to latex? ☐ Yes ☐ No

Details _____

I am aware that the treatment cannot be applied over the head, heart and neck. ☐ Yes ☐ No

This form is completely confidential. By signing below, I agree to the following:

- *The information I have provided regarding my Medical History is accurate to the best of my knowledge.*
- *I understand the information given pertaining to the requested treatment/s and confirm that I do not have any condition/s that would make the treatment/s unsuitable.*
- *I agree to inform my Technician if I experience any discomfort during the procedure, so they may adjust accordingly.*
- *I agree to waive all liability towards my Technician, SNATCHED Rapid Fat Loss or Dominion Aesthetic Technologies for any injury or damages incurred due to my failure to disclose any existing or past health conditions.*

Date: _____

Client Name (Printed) _____

Client Signature _____

SNATCHED RAPID FAT LOSS

SNATCHED TONE (EMS) CONSENT FORM

Please read and initial the following:

_____ *(initial)* I am aware that pregnancy is contraindicated*, and pregnant women cannot undergo the treatment.

_____ *(initial)* I am aware that as is the case with every heat-based therapy, in rare cases, an occurrence of localized overheating of tissue cannot be excluded.

_____ *(initial)* I am aware that the applicators must be in full contact with the bare skin. I am aware that no therapy can be performed through clothing.

_____ *(initial)* I understand that there are certain risks associated with SNACHED TONE (EMS) treatments and they include but are not limited to muscular pain, intramuscular fat decrease, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness, increased menstrual flow in female patients and panniculitis.

_____ *(initial)* I understand that the treatment over injured or otherwise impaired muscles is contraindicated*.

_____ *(initial)* I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks.

_____ *(initial)* I agree to before and after treatment photographs, measurements and weighing, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes.

_____ *(initial)* I understand there are certain contraindications to receiving EMS treatment and I certify that I do not suffer from the following conditions listed on the previous page.

_____ *(initial)* The information I have provided about my medical history is accurate to the best of my knowledge, including all known allergies and/or prescription drugs/products I am currently ingesting or using topically.

_____ *(initial)* I understand the results may vary from person to person and that an exact result cannot be predicted. Completing a full treatment series is necessary to maximize treatment efficacy. It is very unlikely, but it ispossible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations.

_____ *(initial)* I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure, and possible side effects.

_____ *(initial)* I have read the above information, and I request and give my consent to be treated with the SNATCHED TONE (EMS) by designated staff.

_____ *(initial)* I understand that I must remove metal jewelry, particularly electronic watches, and ring monitors (Oura) and put away cell phones and computers as they can be damaged while the device is operating.

I confirm that I am at least 18 years of age and by signing this Consent Form, I agree to waive all liability towards my Technician, SNATCHED Rapid Fat Loss or Dominion Aesthetic Technologies for any injury or damages incurred due to any misrepresentation of my medical history.

Date: _____

Client Name (Printed) _____

Client Signature _____

LED AND EON LASER MEDICAL HISTORY

PERSONAL INFORMATION

FULL NAME _____

D.O.B. _____ AGE: _____ PHONE#: _____

ADDRESS: _____

To perform the LED Light Therapy / EON Smarter Body Contouring in a safe manner, please answer the following health questions truthfully. We will keep all information disclosed in a confidential manner and will use it only for purposes of determining whether you are an ideal candidate for this procedure.

MEDICAL INFORMATION

Are you taking any medication? Please list below: ☐ Yes ☐ No

_____

Do any of the following conditions relate to you?

- ☐ Accutane or other similar medication
- ☐ Autoimmune disease such as HIV, lupus, hepatitis
- ☐ Blood thinners – Heparin, Coumadin, Warfarin, etc
- ☐ Breast Feeding OR Pregnancy
- ☐ Cancer or post-cancer treatments
- ☐ Cardiovascular problems
- ☐ Cold sores or fever blisters without pre-medication
- ☐ Cortisone or steroid injections
- ☐ Cosmetic injections, fillers or implants,
- ☐ Eczema, psoriasis
- ☐ Enlarged or painful glands
- ☐ Epilepsy
- ☐ Facial waxing services, laser procedures, chemical peels, dermabrasion, microderma within 14 days
- ☐ Heart ailment
- ☐ Hypertension/high blood pressure
- ☐ Inflammatory conditions
- ☐ Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
- ☐ Keloids, pigmented scars, icepick scars, new scar tissue
- ☐ Loose, thin, aged skin
- ☐ Lymphatic disorder, inflammation of lymph vessels, lymphedema
- ☐ Pacemaker or metal implants
- ☐ Phlebitis, varicose veins
- ☐ Recent accident or serious injury
- ☐ Recent surgical or dental procedure
- ☐ Rosacea, telangiectasia/couperose
- ☐ Retin-A, Retinol
- ☐ Skin abrasions or lesions
- ☐ Stage III or IV acne
- ☐ Skin-lightening or bleaching agent
- ☐ Sunburn
- ☐ Swollen or infected tonsils
- ☐ Thyroid conditions
- ☐ Type I diabetic
- ☐ Under medical care for an existing or suspected condition or diseas
- ☐ Unrepaired abdominal hernia
- ☐ Viral infection, influenza

Please carefully look over the following list of medications and check off any you have taken in the past 7 days. These medications have been known to cause light sensitivity and it is recommended that you are not on any of the following medications for 7 days before undergoing treatment. **Please be sure to check with your prescribing doctor before discontinuing any prescribed medications.**

- ☐ Anti-Arrhythmic Amiodarone (Pacerone® Cordarone® Aratac®)
- ☐ Chlorpromazine (Thorazine®, Chloramead®, Chlordryprom®, Chlor® Promanyl®, Largactil®, Promapar®, Promosol®, Terpium®, Sonazine®)
- ☐ Acne Oral Isotretinoin (Accutane®, Accure®, Aknenormin®, Amnesteem®, Ciscutan®, Claravis®, Isohexal®, Isotroin®, Oratane®, Sotret®, Roaccutane®)
- ☐ Topical Isotretinoin (Isotrex®, Isotrexin®)
- ☐ Anti-Psychotic Haloperidol (Haldol®)
- ☐ Trifluoperazine (Stelazine®, Clnazine®, Novoflurazine®, Pentazine®, Solazine®, Terfluzine®, Triflurin®, Tripazine®)

LED AND EON LASER MEDICAL HISTORY - CONT.

- ☐ Anti-Fungal Griseofulvin (Grifulvin®)
- ☐ Antibiotics Tetracycline (Helidac®, Terra-Cortril®, Terramycin®, Sumycin®, Actisite®, Bristacycline®, Actisite®, Tetrex®, Doxycycline®, Ciprofloxacin®)
- ☐ Norfloxacin (Noroxin®, Quinabic®, Janacin®)
- ☐ Ofloxacin (floxin®, Oxaldin®, Tarivid®)
- ☐ Nalidixic acid (NegGam®, Wintomylon®)
- ☐ Ciprofloxacin (Cipro®, Ciproxin®, Ciprobay®)
- ☐ Minocycline (Minomycin®, Minocin®, Arestin®, Akamin®, Aknemin®, Solodyn®, Dynacin®, Sebomin®)
- ☐ Oxytetracycline, Demeclocycline, or Lymecycline
- ☐ Cancer Methotrexate (MTX®, Aminopterin®, Ledertrexate®)
- ☐ Arthritis Auranofin (Ridaura®)-If a client is taking this medication, they are not a candidate for light therapy

- Do not perform LED therapy if a client is on steroidal medications. In the case of steroidal injections, it is best to wait at least 7 days before using LED therapy unless you have consent from your client's physician.
- Do not perform LED therapy if a client is 'photo-sensitive', unless you have consent from the client's physician. Some disorders and medications can cause photosensitivity, so check all medications for precautions / risks prior to using LED.
- Chlorpromazine (Anti-psychotic), also know as Thorazine, Chlorpromazine HcL, Sonazine. You can be treated if the medication has not been taken within the last eight days.
- Griseofulvin (Anti-Fungal), also known as Grifulvin V, Fulvicin P/G, Gris-Peg. You can be treated if the medication has not been taken within the last five days.
- Isotretinoin (Anti-Acne), also know as Accutane. You can be treated if the medication has not been taken within the last six months.
- Tetracycline's (antibiotic) also known as Helidac, Terra-Cortril, Terramycin, Sumycin, Tetracycline HcL, Bristacycline, Achromycin V, Actisite, Tetrex, Doxycycline, Ciprofloxacin. You can be treated if the medication has not been taken within the last five days.
- Tretinoin (Anti-Acne), also known as Retin-A, Renova, Atralin, among others. You can be treated if if the medication has not been used within the last 7 days.
- Methotrexate (Anti-Arthritis & Anti-Cancer), also known as Methotrexate Sodium, PF & LPF, Mexate-AQ, Folex, Trexall. You can be treated if the medicine has not been taken within the last three days.
- Amiodarone (Anti-Arrythmic), also known as Amiodarone Codarone x, Pacerone. Treatment can be administered only with your physician's written permission.

The above drugs are currently the most common medications associated with photosensitivity and are by no means a complete list of all photosensitive medications. Herbs and over the counter medications such as psoralen and St. John's Wort can also cause sensitivity to light, so it is important to disclose any and all medications or herbs you are currently taking. ***Please list any additional medications NOT listed above or any herbs you may currently be taking or have taken in the past 7 days***

_____

Have you undergone any cosmetic/aesthetic treatments in the last 24 hours? ☐ Yes ☐ No

Do you use sunbeds or are regularly exposed to sun? ☐ Yes ☐ No

- Do not perform LED therapy on someone that is pregnant or nursing or has known metastasis.
- Do not perform LED therapy on someone with a seizure disorder, unless you have consent from the client's physician.
- You must wait five days after Botox or cosmetic fillers.
- Do not perform LED therapy if a client has a history of skin cancer
- Do not perform LED therapy if a client has Systemic Lupis erythematosus should also avoid this kind of treatment.
- Do not perform LED therapy if a client has a history of diseases that involve the retina of the eye, unless you have consent from the client's physician.
- Please consult with physician before discontinuing any medication

Acknowledgement & Consent to proceed with treatments:

I have read, answered, and understood the above questions and I confirm that the above information that I have provided is true, full and an accurate statement of my current physical and medical status.

I confirm that I am at least 18 years of age and by signing this Consent Form, I agree to waive all liability towards my Technician, SNATCHED Rapid Fat Loss or Dominion Aesthetic Technologies for any injury or damages incurred due to any misrepresentation of my medical history.

Client Signature: _____ Date: _____

SNATCHED
RAPID FAT LOSS

LED CONSENT FORM

Risks and Side Effects:

LED Light Therapy sessions are non-invasive and are intended not to produce any thermal damage or pain. Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. It is important to notify the technician if you have any problems or concerns such as uncomfortable heat from the pad or panel, prolonged redness of the skin, swelling, itching or severe headaches during or immediately after the session. These are all indications of sensitivity to light in which case you would want to discontinue the session immediately. These side effects rarely occur and usually subside within 24 hours of discontinuing the session. It is also important to notify the technician if any conditions to your medical history change such as becoming pregnant or diagnosis of a medical condition. To prevent any light sensitivity or irritation, protective eyewear may be worn during all treatment sessions.

Please initial below to confirm your agreement and understanding:

_____ *(initial)* I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

_____ *(initial)* I understand the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. Alternative choices are available. With this in mind, I am choosing this noninvasive treatment option.

Pre and Post Session Instructions:

It is important that the treated area be cleaned to remove all moisturizers and creams prior to starting any treatment session. In order to maximize the benefits, you must be well hydrated before and after all sessions, practice healthy eating habits, limit sun bathing, alcohol consumption, and smoking while undergoing your series and up to six weeks following your sessions. Most clients will continue to see a marked improvement in their skin over the 12 week protocol period even after the initial LED Light Therapy sessions have concluded. As with any cosmetic protocol, individual clinical results will vary from person to person and no guarantees can be made that expected or anticipated results will be achieved

Although every precaution will be taken to ensure your safety and wellbeing before, during, and after your LED session, please be aware of the following information and possible risks. Please initial each line below:

_____ *(initial)* 1. I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months.

_____ *(initial)* 2. I acknowledge that if I have ever had a cold sore or fever blisters, I should consult with my physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation treatment.

_____ *(initial)* 3. I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen.

_____ *(initial)* 4. I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending on skin sensitivity.

LED CONSENT FORM

SNATCHED RAPID FAT LOSS

_____ *(initial)* 5. I acknowledge to use use a minimal sunscreen (SPF 15) 48 hours after treatment, as I am more susceptible to sunburn, skin damage & hyperpigmentation.

_____ *(initial)* 6. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied.

_____ *(initial)* 7. I acknowledge that I should avoid use of glycolic products for 2-4 weeks following the treatment.

_____ *(initial)* 8. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my medical or skincare professional during and following the treatment.

_____ *(initial)* 9. I acknowledge that I am not pregnant/lactating.

_____ *(initial)* 10. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions, which are noted above and of which I have a copy to follow for each session.

_____ *(initial)* 11. I acknowledge that I have answered all questions truthfully and completely.

_____ *(initial)* 12. I acknowledge there are certain contraindications that would preclude me from receiving LED Light Therapy sessions, including some discussed on this form.

_____ *(initial)* 13. I acknowledge there are other precautions that should be considered before receiving LED Light Therapy sessions and may require a doctor's release and/or I assume any risk involved.

_____ *(initial)* 14. I acknowledge that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

_____ *(initial)* 15. I acknowledge that some clients report slight tingling sensations and flashing of the optic nerve during the procedure.

_____ *(initial)* 16. I acknowledge that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

_____ *(initial)* 17. I acknowledge that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

_____ *(initial)* 18. I release the management and staff of SNATCHED Rapid Fat Loss from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

_____ *(initial)* 19. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes.

What are your goals and expectations of the LED Light Therapy treatment?

_____

I will not hold SNATCHED Rapid Fat Loss, Dominion Aesthetic Technologies or its employees/affiliates liable for any LED Light Therapy Treatment(s) I receive or for any side effects that may occur following treatment.

Date: _____

Client Name (Printed) _____

Client Signature _____

EON LASER CONSENT FORM

Before and After Treatment Instructions:

It is important that the treated area be cleaned to remove all moisturizers and creams prior to starting any treatment session. In order to maximize the benefits, you should maximize water intake, practice healthy eating habits, alcohol consumption, and smoking while undergoing your treatment. As with any cosmetic protocol, individual clinical results will vary from person to person and no guarantees can be made that expected or anticipated results will be achieved

Risks and Side Effects:

Common Side Effects

- Light redness.
- Mild to moderate discomfort or pain during the treatment.
- Soreness / tenderness.
- Nodules: a nodule is a lump of dead fat cells beneath the skin that usually resolves on its own in a few weeks but could last up to a few months. Massaging the area helps resolve the nodule.

Rare Side Effects

- Burns, Blisters, Hypo/hyper pigmentation, Chronic pain, Nodules lasting more than 12 months

Contraindications:

- Sunburn
- Large tattoos in the treatment area.
- Active inflammation or infection (e.g. fever).
- Dermatitis, rash or open wound in the treatment area.
- Pregnant or lactating.
- Known skin cancer in the treatment area.
- Undergoing systemic chemotherapy for treatment of cancer.
- Injections in the site of the treatment 7 days previous.

Do you have any of the following:

- ☐ A history of a photosensitivity disorder or use of photosensitizing medication.
- ☐ Type I diabetes.
- ☐ Autoimmune or collagen-vascular disorders (e.g. lupus, scleroderma).
- ☐ History of seizures / epilepsy.
- ☐ History of keloid scars.
- ☐ Ongoing use of steroids or other anti-rheumatoid drugs.

Please initial below to confirm your agreement and understanding:

_____ *(initial)*
I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

_____ *(initial)*
I understand the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. Alternative choices are available. With this in mind, I am choosing this noninvasive treatment option.

_____ *(initial)*
Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

EON LASER CONSENT FORM

Risks:

If you do not understand what any of these side effects mean, please ask the device operator to explain these terms to you. There may be rare and unknown side effects. Some of these may be life threatening. You must tell the device operator or Dominion staff about all side effects that you have.

Incase of device related injuries:

In case of injury, the on-site doctor may provide urgent medical care. Please be aware that some insurance plans may not pay for aesthetic procedures injuries. You should contact your insurance company for more information.

Birth Control, Dangers of Pregnancy and Breastfeeding:

If you are a natural born female, you must confirm that you are not pregnant or trying to get pregnant while receiving the treatment.

If you are pregnant or become pregnant during the treatment, the treatment may involve unforeseeable risks to the unborn baby. A pregnancy test is not always right, especially in the early stages of pregnancy.

Acknowledgement:

I have been thoroughly and completely advised regarding the end point of the procedure. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized.

There is no guarantee that the expected or anticipated results will be achieved. I have been informed that firmness, hardness, nodules, redness, tenderness, swelling, pain, and bruising, are the most common side effects. Other less common side effects which can occur are itching, skin contour irregularities, dimpling, hyperpigmentation/hypopigmentation, asymmetry, necrosis, changes in skin laxity, numbness, blisters or burn. Rare occurrences of fainting or dizziness have been noted during and/or after the treatment.

What are your goals and expectations of the EON Body Contouring treatment?

_____

I will not hold SNATCHED Rapid Fat Loss, Dominion Aesthetic Technologies or its employees/affiliates liable for any EON Smarter Body Contouring treatment(s) I receive or for any side effects that may occur following treatment.

Date: _____

Client Name (Printed) _____

Client Signature _____

SNATCHED
RAPID FAT LOSS

APPOINTMENT CANCELLATION POLICY

Payment: Payment for ytour monthly membership must be received on or before the first day of treatment. We offer the following payment options:

Cash or Check: We accept Credit Card payment along with financing options from Cherry and Care Credit.

Credit Cards: We accept Visa, MasterCard, American Express and Discover.

Punctuality: Please arrive 15 minutes early so you can prepare for your treatment and enjoy the experience.

Arriving late: By arriving late, you will disrupt your treatment, reducing the time available for the treatment. Your treatment will end at your scheduled time and there will be no disruption with the next appointment.

No show: We recommend that you get in touch with us and let us know if you will be late. No shows lead to the disengagement or voiding of any agreements you may have with our office.

Should you fail to arrive for your scheduled appointment without notifying us in advance, your deposit or future appointments may be forfeited.

Cancellation: The scheduling policy of our office is very strict due to the time constraints of procedures. Due to this, we ask that you respect our one-week cancellation/rescheduling policy.

If you have questions regarding this policy, please let us know, and we will be happy to clarify our policy for you.

I have read and understand the Appointment Cancellation Policy, and I agree to be bound by its terms. I am aware that my credit card will be charged for the missed appointment, and I agree to this terms.

I,_____ , have received the copy of Cancellation Policy.

Date: _____

Client Name (Printed) _____

Client Signature _____

PHOTO & VIDEO RELEASE FORM

I, _____ , hereby grant and authorize SNATCHED RAPID FAT LOSS the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, video, and/ or audio taken of me to be used in and/ or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print or digital communications without payment or any other consideration.

This authorization extends to all languages, media, formats, and markets now known and later discovered.

I will be consulted about the use of the photograph and/ or video recording for any purpose other than those listed below:

- Promotional materials;
- Printed and/ or digital advertisements;
- Educational presentations or courses;
- Informational presentations;
- Online educational courses;
- Educational videos;
- Social media posts.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Date:_____

Client Name (Printed) _____

Client Signature _____