Informed Consent

Ultrasonic Cavitation is a non-invasive technology which breaks down fat cells. This procedure is non-surgical, does not require anesthesia or hospitalization, and no downtime. Cavitation Lipo is a stress-free way to rid your body of stubborn fat which remains even after diet and exercise. The most common challenging areas are abdomen, love handles, inner thighs, buttocks, chin and, arms. The goal of this treatment is to reduce inches in a targeted area by utilizing low frequency sound waves.

Following the recommended treatment plan will optimize your results. Appointment length is usually 45min treatment time and are scheduled 2-3 times per week. Treatment recommendation will vary per individual and **on occasion some patients do not respond.**

I have been informed and understand goals, limitations and, possible complications with this procedure. All treatment options have been discussed with me including alternate treatment methods should I not be a candidate for Cavitation Lipo.

I have been given opportunity to ask questions about this elective procedure. All my questions have been answered and limitations, complications and, side effects have been discussed.

I agree to and understand the following:

The purpose of treatment is to improve areas of concern. I understand results may vary due to genetics, hormones, nutrition, topical applications, or unpredictable reactions.

Due to the nature of this procedure, I must notify staff of any past or current Herpes Simplex infections. Herpes around the mouth can occur following treatment. Should any infection occur post treatment please seek treatment advise from your physician.

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In rare occasions allergic reactions can occur from products and material used during treatment. Please notify your technician if you have any allergies.

ALLERGIES: ____

Systemic reactions may result from medications. Please list all prescription and non-prescription medications you are taking.

MEDICATION: ____

It is essential to maintain aftercare compliance to preserve results. Patients may require different treatment plans based on diet or health history. Follow recommended aftercare instructions given by your technician.

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Unforeseen circumstances may occasionally occur resulting in rescheduling of your appointment. This may include but not limited to power outage, equipment malfunction or emergency. We will make every effort to respect your time by notifying you in advance.

Possible side effects include but are not limited to:

Diarrhea, headaches, toothaches, bruising, ringing in ears, kidney failure, liver failure (fatty infiltration of the liver), pacemaker or other electronic device malfunction, hypertriglyceridemia, or hypercholesterolemia. These symptoms or side effects are normal and cannot be predicted. Side effects vary with each patient.

I understand that the technician can decide if treatment is NOT appropriate.

Declination of treatment or doctors release may be required for the following:

Presence of plastic or metallic prosthesis/ plates/ devices

Acute inflammatory disease

Tumors or cancer

Kidney/ Liver disease

Cutaneous lesions

Active infections/herpetic lesions/ hives

Proximity of organs and bone marrow

Pacemaker

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High blood pressure

Heart problems

Pregnancy/ breastfeeding

Epilepsy

Gallstones

Diabetes

Extreme sensitivity or allergic reaction in treatment area

Hemorrhagic disease / clotting/ blood disorder

Abnormal immune system

Numb or sensitivity issues

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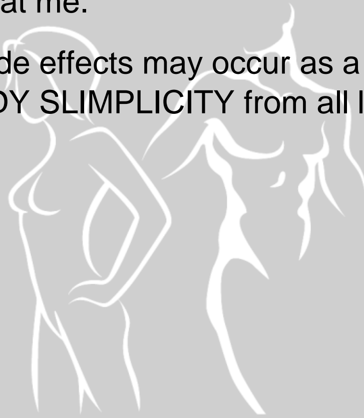
Acknowledgement

I have read and understand all the above. I was given opportunity to ask all questions or address any concerns I have regarding Cavitation Lipo treatment. Pre-treatment and aftercare instructions were fully explained to me. I understand and am responsible for following aftercare instructions provided.

All treatment fees have been discussed and I understand them entirely.

My questions regarding treatment were answered to my satisfaction. I understand the procedure and accept the risks. I hereby release BODY SLIMPLICITY and its agents from all liabilities associated with treatment. By signing this form, I am giving BODY SLIMPLICITY permission to treat me.

I understand symptoms and side effects may occur as a result of treatment (during or after). Therefore, I release BODY SLIMPLICITY from all liability regarding these occurrences.



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X

Patient Signature:

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Each client will receive a full consultation before treatment. At this time, we will discuss the target areas, goals, treatment plan, and aftercare to achieve optimal results. All patients MUST sign indicating they have read, understand and, consent to treatment which was discussed during consultation. This consent form is an agreement between the named patient and BODY SLIMPLICITY (including agents) that the patient fully understands the treatment he/ she is agreeing to. Patient also acknowledges understanding of pre- and post- treatment instructions, side effects, symptoms, and reactions which may occur. If the technician is misled by the patient for any reason, patient understands he/ she is fully responsible for the post-treatment consequences.

Should you have any questions or concerns please contact BODY SLIMPLICTY. Your satisfaction is very important to us which is why it is imperative we educate our patients to fully understand the body contouring procedure/s. We want our patients to have an educated understanding and trust in our services.

Owner: Heather Galvan

Phone: 214-600-2040

Location: 1929 Lemita Dr. Lancaster, Texas 75146

Website: bodyslimplicity.com

Facebook: www.facebook.com/bodyslimplicity

Instagram: @bodyslimplicity

Body Slimplicity, LLC

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X ______________________________

Patient:

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Arbitration Agreement

I understand and agree any dispute concerning medical malpractice will be at my cost which includes legal costs for both parties.

I understand and agree any dispute concerning medical malpractice will be determined by arbitration: the term medical malpractice interpreted broadly and shall include any and all claims tort, contract, lack of informed consent, or other legal theories which in any way pertain to claims or unnecessary, unauthorized, improper, negligent, or incompetent, rendering of medical treatment.

I understand I am giving up my rights to bring a lawsuit or to resort to any court process except as Texas Law provides for judicial review of arbitration proceedings.

By signing the agreement, I agree I shall resolve all disputes by arbitration rather than through court.

I understand and agree this Arbitration Agreement binds me and anyone else who may have the right to assert a claim on my behalf or make claim as a result of injury to me. I also understand that is I sign this agreement on behalf of someone else, I am binding to this agreement.

I understand and agree that this agreement relates to claims against the technician and all consenting substitutes technicians, their partnerships. Professional corporations, employees, heirs, assigns or successors in interest.

I understand that this legal document and I have been advised of my rights to obtain legal counsel before signing this agreement. By signing this agreement, I fully understand this agreement contains terms and conditions relating to arbitration.

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I understand, I am forfeiting my rights to any trial. The damages awardable at arbitration are limited to those available under Texas state law.

Within fifteen (15) days after a party to this agreement has given written notice to the bother of demand for arbitration of a dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

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Any party to this agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite its absence at the arbitration hearing. I understand that my request for arbitration concerning alleged medical malpractice must be made within the statute of limitations for filing any claim of malpractice as provided by Texas law and failure to seek arbitration within the applicable statute of limitations will forever prevent the submission of any claims.

The patient has the right to rescind this agreement by written notice to the provider of services within three (3) days after the agreement has been signed and executed. The client may rescind by merely writing "cancelled" on the face of one of his or her copies of this agreement, signing his name under such word, and mailing, by certified mail. return receipt requested, such copy to the provider of medical services with such three (3) day period.

With respect to any dispute or controversy that is made subject to arbitration under: the terms of this agreement, no suit at law or in equity based on such dispute or controversy shall be instituted by either party, except to enforce the award of the arbitrators.

X ______________________

Patient

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___________ I agree my medical history and medications are true and correct.

___________ I understand photographs will be taken during the course of my treatment for my medical record.

___________ I consent to using my photographs for:

- ☐ **Marketing**
- ☐ **Social media**
- ☐ **Training purposes**

___________ My name will not be used to identify my photographs

___________ I am not pregnant or nursing

___________ I have been given the opportunity to as questions about the procedure/s and all questions have been answered. I understand information given to me

___________Contraindications to the performance of this procedure have been discussed in detail with me

___________ I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.

___________ I have read and understand all information presented to me before signing this consent form.

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24 HOUR CANCELLATION POLICY IS REQUIRED. There is a $30 no-show or late cancellation fee which will be charged to your card on file.

REFUND POLICY: There is a no refund policy, all sales are final. If you pay in advance your funds will be applicable for future services up to six (6 Months) or may be transferred to a friend or family member. To prevent fraud, you will have to give written permission for transfers.

I CONFIRM I AM VOLUNTARILY PARTICIPATING IN THE AFORMENTIONED PROCEDURE/S AND I AM PARTICIPATING IN THE PROCEDURE/S ENTIRELEY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH THE PROCEDURE/S WHICH MAY INCLUDE BUT ARE NOT LIMITED TO DIARRHEA, HEADACHES, TOOTHACHES, BRUISING, RINGING IN EARS, KIDNEY FAILURE, LIVER FAILURE (FATTY INFILTRATION OF THE LIVER), PACEMAKER OR OTHER ELECTRONIC DEVICE MALFUNCTION, HYPERTRIGLYCERIDEMIA, OR

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HYPERCHOLESTEROLEMIA, PHYSICAL PAIN OR INJURY. I UNDERSTAND THAT THESE OUTCOMES MAY ARISE FROM MY OWN NEGLIGENCE OR

UNDERLYING HEALTH CONDITIONS. NONETHELESS, I ASSUME ALL RELATED RISKS BOTH KNOWN AND UNKNOWN TO ME.

I agree to indemnify or hold harmless BODY SLIMPLICITY or its agents against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation, or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or anyone acting on my behalf. If Body Slimplicity or its agents incurs any of these expenses, I agree to reimburse Body Slimplicity (agents).

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS CONSENT AND FULLY UNDERSTAND THAT IS A RELEASE OF LIABILTY. I EXPRESSLY AGREE TO RELASE AND DISCHAGE **BODY SLIMPLICITY** AND ALL ITS AFFILLIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLENTEERS, HEIRS, REPRESENTATIVES, PREDESSESORS, SUCCESSORS, AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLENTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST **BODY SLIMPLICITY** FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases or negligence, this release is also for negligence on the part of BODY SLIMPLICITY, its agents, and employees.

If I should require medical care or treatment, I agree to be financially responsible for incurred as a result of each treatment.

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X

Patient

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