Non invasive Body Treatment

(CONFIDENTIAL INFORMATION)

Name:	
Occupation:	**Date of Birth:**
Phone No.:	**Email:**
Address:	
City:	**State:** **Zip Code:**
Emergency Contact Name & Number:	
How did you hear about us?:	**Do you want us to email you promotions?**

Medical History

Please check all that apply

- ☐ Bleeding Disorder
- ☐ Broken Bones
- ☐ Cancer/Tumor
- ☐ Cardiovascular Problems
- ☐ Metal Implants
- ☐ Organ Failure
- ☐ Diabetes
- ☐ Dislocations
- ☐ Ulcerated Skin
- ☐ Heart Disease
- ☐ Hernias
- ☐ Hives/Herpes/Shingles
- ☐ Infection
- ☐ Pregnant/Nursing
- ☐ Transplant(s)
- ☐ Skin Disease
- ☐ Sunburn
- ☐ Unhealed Wounds
- ☐ Infectious Disease
- ☐ Insulin Monitor
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker/Other Electronic Device
- ☐ Transdermal Drug Delivery System
- ☐ Epilepsy
- ☐ Fever

Do you have any other medical conditions that we should know about? ☐ Yes ☐ No

If yes, please list: _____

Are you currently taking any medications (including but not limited to blood thinners)? ☐ Yes ☐ No

If yes, please list: _____

Do you have any allergies? ☐ Yes ☐ No

If yes, please explain: _____

Have you had any surgery within the past 12 months? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any medical devices implanted including but not limited to hearing aids, a pacemaker, or hormonal pellets? ☐ Yes ☐ No

If yes, please list: _____

When was the first day of your last menstrual cycle?

Do you use recreational drugs? ☐ Yes ☐ No

If yes, please list: _____

Service Information

What concerns would you like addressed today?

Do you want to lose body fat? ☐ Yes ☐ No

If yes, from what area: _____

Do you want to tighten skin on your body? ☐ Yes ☐ No

If yes, from what area: _____

Do you want to reduce cellulite? ☐ Yes ☐ No

If yes, from what area: _____

Please list your regular exercise habits: _____

Please describe your current dietary habits: _____

How many ounces of water do you drink daily? _____

By signing below, I agree to the following

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the spa for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date

Vacuum Therapy (Butt Lift) Informed Consent Form

(CONFIDENTIAL INFORMATION)

Patient Name:

The Vacuum Therapy (Butt Lift) is a non-invasive treatment. It uses a vacuum applicator to draw in skin tissue. The procedure is for improving the appearance of cellulite and reducing circumferences and that it may also be therapeutic for improving circulation and muscle aches in the treated areas. It is not a weight-loss solution and it does not replace traditional methods such as liposuction.

I authorize (Facility Name) to perform Vacuum Cupping Treatment on me.

_____ **(patient initials)**

I understand that:

The Vacuum Therapy (Butt Lift) is a device used for improving the appearance of cellulite in the treated areas. I understand there is a possibility of short-term effects such as discomfort, reddening, temporary bruising and temporary discoloration of the skin as well as rare side effects, just as scarring and permanent discoloration.

These effects have been fully explained to me. _____ **(patient initials)**

I understand that:

The suction pressure may cause sensations of deep pulling, tugging and pinching. You may experience intense stinging, tingling, aching or cramping as the treatment begins.

These effects have been fully explained to me. _____ **(patient initials)**

I understand that:

Clinical results may vary depending on individual factors, including but not limited to the medical history, skin type patient compliance with pre- and post-treatment instructions, and individual response to treatment.

These effects have been fully explained to me. _____ **(patient initials)**

I understand that:

Bruising, swelling, and tenderness can occur in the treated area and it may appear red for a few hours after the treatment.

These effects have been fully explained to me. _____ **(patient initials)**

I understand that:

The Vacuum Therapy (Butt Lift) involves a series of treatments and the fee structure has been fully explained to me.

_____ **(patient initials)**

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

_____ **(patient initials)**

I confirm that I have informed (Hospital / Clinic Name) regarding any current or past medical condition, disease or medication taken. _____ **(patient initials)**

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. _____ **(patient initials)**

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the context of this consent form. _____ **(patient initials)**

Do you have any of the following?

Neuropathic disorders such as post-herpetic neuralgia or diabetic neuropathy ☐ Yes ☐ No

Impaired skin sensation ☐ Yes ☐ No

Open or infected wounds ☐ Yes ☐ No

Bleeding disorders or concomitant use of blood thinners ☐ Yes ☐ No

Recent surgery or scar tissue in the area to be treated ☐ Yes ☐ No

A hernia or history of hernia in the area to be treated ☐ Yes ☐ No

Skin conditions such as eczema, dermatitis, or rashes ☐ Yes ☐ No

Pregnancy or lactation ☐ Yes ☐ No

Infection in the urinary system i.e. kidneys, bladder and urethra ☐ Yes ☐ No

Crohn's Disease ☐ Yes ☐ No

Hyperthyroidism ☐ Yes ☐ No

Deep Venous Thrombosis ☐ Yes ☐ No

Lymphedema ☐ Yes ☐ No

Impaired peripheral circulation in the area to be treated ☐ Yes ☐ No

CONTRAINDICATIONS

Diabetes – the body's inability or lowered ability to regulate blood sugar and fat levels can significantly hinder the proper removal of fat cell contents from the lymphatic system, thus lowering the overall effectiveness of the treatments

Thyroid problems – thyroid regulates overall metabolism of the body, thus it can deter the proper disposal of fat contents from the body, and hence also lower the overall effectiveness of the treatments

Current or history of skin cancer or pre-malignant moles – In order to avoid and prevent any further irritation to these conditions' treatment of body areas with these conditions should not be performed. We recommend you talk with your physician before committing to any treatment.

Any active skin conditions – It is best to schedule treatment when any skin conditions in treatment areas such as sores, psoriasis, eczema, herpes and rashes are no longer active to avoid and prevent any further irritation of skin.

Alcohol and Caffeine – These substances will slow down lymphatic drainage of fatty acids and toxins. For best results, please try to avoid or reduce your intake of products that contain them during the course of treatment.

Infection in the urinary system i.e. kidneys, bladder and urethra
Crohn's Disease
Hyperthyroidism
Deep Venous Thrombosis
Lymphedema

Medical Information: Please circle all that pertain to you.

SERVICE MUST BE POSTPONED IF ANY OF THE FOLLOWING APPLY TO YOU

- Accutane Pace Maker
- Botox/Dysport within the past 2 weeks.
- Cancer or post-cancer treatments
- Retin A within 5-7 days of treatment
- Sunburn
- Recent laser procedures or chemical peels within the past
- Blood Thinner Medication
- Viral Infection/influenza/cold sore
- Infection in the urinary system i.e. kidneys, bladder and urethra
- Crohn's Disease
- Hyperthyroidism
- Deep Venous Thrombosis

SERVICE MAY STILL BE PROVIDED BY (Facility Name)'S DISCRETION:

- I understand and acknowledge that cupping is performed by suction at certain points on the body in an attempt to treat buttocks enhancement, slimming, detox, anti-cellulite, pain management, and to stimulate lymphatic drainage. I am aware and acknowledge that certain adverse side effects may result.
- I understand there are no guarantees regarding its use and effects and that I am free to stop the cupping treatment at any time.
- I understand that vacuum cupping does commonly leave marks on the skin that vary in pattern and color (from light to dark purple) and usually lasts 3 days to a week, and sometimes longer.
- I will inform (Facility Name) if my medical condition changes over the course of treatment.
- By signing below, I certify that I have been given the opportunity to ask questions and that I have read and fully understand the context of this consent form.

Print name: _____

Signature: _____

Date: _____

Appointment Cancellation Policy

Dear Client

We strive to render excellent care to you and the rest of our clients. Your care and treatment is a priority for us. We also ask that you respect your specialist's time and expertise as well.

In an attempt to be consistent with this, we have a Cancellation Policy that allows us to schedule appointments for our clients, with respect for your time, the next client's time, and the specialist's time.

Our policy is as follows:

We request that you give a notice **no later than 24 hours** prior to your scheduled appointment in the event that you can not make it. If the client misses an appointment without contacting us, it is considered a missed or "no show" appointment. Additionally, if a client is more than 10 minutes late for an appointment, it will be considered as a "no show" appointment, and that appointment will be rescheduled. Also, if you miss more than 3 (three) appointments, we reserve the right to charge you a fee of $150

A $35 non-refundable deposit will be paid at time of making the appointment and will be taken off at the time of the appointment.

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 understood 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 these terms.

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

Print name: _____

Signature: _____

Date: _____

Body Sculpting Consent Form

(CONFIDENTIAL INFORMATION)

Thank you for your interest in having your body sculpting procedure with us. We are with you on your desire to reach your goals for a better body that helps boost your confidence and bring a better lifestyle. We have provided some information that can help you achieve your best results:

1. Drink plenty of water before and after treatment
2. Have a 2-hour fast prior to treatment
3. Perform some physical activity such as exercise
4. Manage your food intake
5. Avoid alcoholic drinks and those with high sugar before and after treatment

Please take note that results may vary for the treatment.

During the treatment, you might feel a warm discomfort. If it's not tolerable, please advise our technician.

At an average, you can expect a reduction from 0.5 inches to as much as 2.0 inches after a treatment.

Name:		**DOB:**
Phone No.:	**Email:**	
Address (Street Line 1):		
Address (Street Line 2):		
City:	**State:**	**Zip Code:**

Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Contact In Case Of Emergency

Name:	
Phone No.:	**Relationship:**

Treatment ☐ Cellulite reduction ☐ Non-surgical facelift ☐ Ultrasonic Cavitation ☐ Non-surgical lipo

Areas To Be Treated ☐ Abdomen ☐ Arms ☐ Buttocks ☐ Cheeks ☐ Chin ☐ Legs ☐ Thighs

Medical History	Yes	No
Are you pregnant or nursing?		
Are you immunocompromised?		
Do you have any liver or kidney disorders?		
Do you have any thyroid gland dysfunction?		
Do you have epilepsy?		
Do you have cancer or a history of cancer?		
Do you have photosensitivity to sun exposure?		
Are you taking any drugs that may cause photosensitivity?		
Have you undergone an organ transplant?		
Do you have any current infections?		
Do you have advanced untreated diabetes?		
Do you have uncontrolled Hypertension?		
Do you have any kind of heart condition?		
Do you have hemophilia (blood clotting condition)?		
Do you have a keloid scar?		
Do you have any infectious disease or tuberculosis?		
Do you have a pacemaker?		

If you have answered 'Yes' to any of the medical conditions above, we advise you to see your doctor first before undergoing treatment with us. We reserve the right to not begin any treatment should we believe that such treatment may cause risk to our client due to the medical conditions which the client has.

Reminder:

- [ ] Please make sure that there are no metal instruments that are present on or in your body during the scheduled treatments. If you have any heart or liver problems, uncontrolled high blood pressure, or cancer or undergoing radiology treatments, please see your doctor first. However, if you have a pacemaker, it is unfortunate that we cannot proceed with any of the services that we offer.

CONSENT

I hereby declare that I am of legal age and I understand that treatments for body sculpting do not guarantee absolute results. In order to achieve my desired results, I may be required to undergo several treatments with an appropriate diet and physical activity. I understand that non-invasive surgery procedures do not rid the body of visceral fat.

I hereby release and forever discharge the Clinic, its affiliates, partners, agents, and employees from any and all causes of action. I will hold harmless, the Clinic for any liabilities, damages, injuries whether seen or unforeseen.

I understand that any procedure under the Clinic does not constitute medical treatment or cure to any illness.

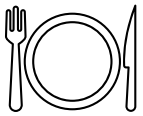
By signing this form, I declare that all information and declarations I have made above are true and correct to the best of my knowledge. I have had the opportunity to ask questions and which were answered to me and to my satisfaction. I have likewise read all the information above and give my consent with my full knowledge, understanding, and assumption to the risks involved in the treatment, without any coercion, inducement, or undue influence.

Date _____ Signature _____

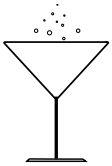
Pre and Post-Care

HOW TO PREPARE FOR YOUR TREATMENT

Drink at least a liter of water before treatment



Do not eat 1 hour before treatment

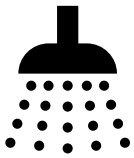


Refrain from any alcohol the day of treatment

Some clients may experience detoxification symptoms such as weakness, headache, dehydration, large bowel movement, and fatigue. Light bruising is also normal.

WHAT TO DO AFTER YOUR TREATMENT

Drink plenty of water to help eliminate toxins out of the body



Avoid showers, sauna, hot bath for at least 4-6 hours

Exercise for at least 20 min to stimulate lymph movement

Light stretching and range of motion exercises are beneficial

No eating for 1 hour after treatment

Book your next appointment in a timely manner

Vacuum Therapy (Butt Lift) Pre and Post-Care

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