Body Sculpting

Consultation Form

Email/Newsletter

Would you like to be added to our V.I.P. email list in order to receive updates about upcoming discounts, promotions, contests etc?

- ○ *Yes, sign me up!*
- ○ *No, thanks*

Appointment date _____ *Appointment time* _____

Personal Information

FULL NAME

D.O.B. AGE: PHONE#:

ADDRESS:

To perform the Body Sculpting procedure 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.

Have you ever had any weight loss treatments previously? ☐ Yes ☐ No

If yes, please specify .....

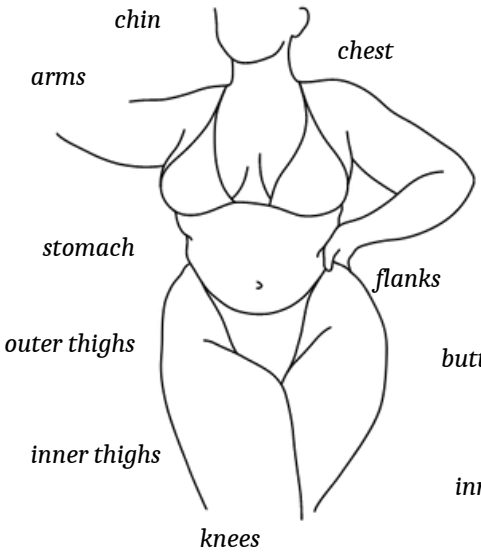
What would you like to achieve from your treatment today?

.....

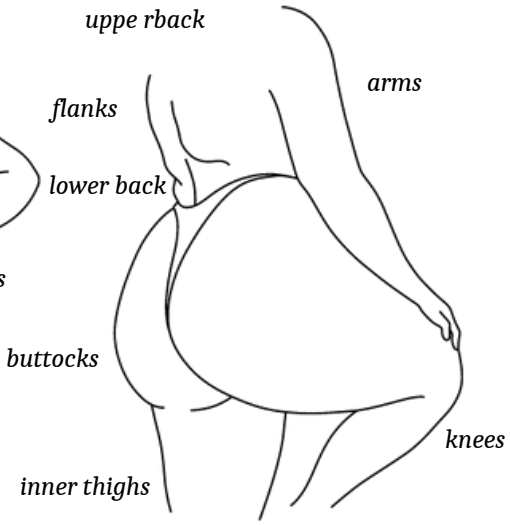
Do you exercise? If yes, how often and what type?

.....

CIRCLE BODY AREA/S WOULD YOU LIKE TO FOCUS ON



FRONT



BACK

Do you currently follow any specific diet system? ☐ Yes ☐ No

If yes, please describe .....

Do you drink water daily?

- ☐Yes, 1 to 2 bottles daily
- ☐Yes, 3 to 4 bottles daily
- ☐Yes, 5 to 6 bottles daily
- ☐Yes, more than 8 bottles daily
- ☐No, I do not drink water regularly
- ☐No, I do not drink water at all

Do you eat breakfast?

- ☐Yes, before 8am
- ☐Yes, between 8am and 10am
- ☐After 10am
- ☐No, I do not eat breakfast

BODY ANALYSIS

Weight

BMI

Body Fat %

Muscle %

Body Age

Visceral Fat Level

Do you have any implants?

- ☐Metal
- ☐Electrical Wire
- ☐Birth Control Cosmetic
- ☐Other

Are you using any skin thinning products and/or drugs that thin the blood?

- ☐Yes
- ☐No

List any medications, supplements, or herbal remedies you currently take:

.....

.....

How often do you consume alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Never

MEDICAL HISTORY

Do you have type 1 or type 2 diabetes?	☐ Yes	☐ No
Do you have any known liver disorders?	☐ Yes	☐ No
Do you have any known kidney disease?	☐ Yes	☐ No
Do you have photosensitivity to sun exposure?	☐ Yes	☐ No
Do you currently have cancer?	☐ Yes	☐ No
if yes, do you currently on chemotherapy?	☐ Yes	☐ No
Have you had cancer in the past 12 months?	☐ Yes	☐ No
Do you have any thyroid problems?	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No
Do you have any cardiovascular conditions?	☐ Yes	☐ No
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 .....

YOU MUST NOT HAVE TREATMENT IF YOU HAVE ANY OF THE FOLLOWING:

☐Heart Disease

☐Hypertension Diabetes

☐Poor Blood Circulation

☐Hyperlipidemia (abnormally high concentration of fats or lipids in the blood)

☐ Pace maker & Metal Implants

☐Skin Inflammation/wounds in treatment area

☐ Vascular Veins

☐Cancer

This form is completely confidential. Completion of form gives the general state of health and assists our specialist in directing a customized course of treatment for you.

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health conditions.

Date:_____ Date: _____

Client Name (Printed)_____ Therapist Name _____

Client Signature _____ Therapist Signature _____

Consent Form

Any medical or cosmetic procedure carries risk, complications and varied results as to the effectiveness of a particular treatment. The purpose of this document is to make you aware of the nature of procedure and its risks in advanced so that you can decide whether to go forward with any procedures/treatments.

PROCEDURES

Initially you will consult with the consultant to determine if you are a candidate for Body Sculpting Cavitation or other inch loss procedures. During this time you will have the opportunity to ask questions or voice concerns you may have regarding this treatment. If it is determined you are a candidate for any procedure, there will be a few preliminary steps consisting of: initial paperwork, measurements, pre and post treatment photos and suggested course of treatment. It is recommended that a client will need a minimum of 6 or more treatments for the therapy to achieve its desired effect. These treatment should be used in conjunction with a healthy diet and exercise. If you are not currently exercising you should consult a health care professional before beginning an exercise program to determine if your body is physically able.

RISK/DISCOMFORT

Our treatments are non-invasive. During treatment there should be no discomfort. If for any reason during treatment that the client feels discomfort due to warmth or any discomfort, treatment will be terminated. Client should report this discomfort to technician immediately. If client chooses to continue through any discomfort, it is at the client's own risk and provider assumes no responsibility. Procedures are recommended for anyone over 18.

BENEFITS

The potential benefit of this treatment is body contouring without surgery. Problem areas or excess pockets of fat can be targeted, however the most commonly treated areas are the stomach, hips, flanks, and thighs. In clinical trials patients have averaged 2-5cm lost from there stomach, hips, and thighs. These results do vary and no guarantee is implied or suggested that desired results will be achieved.

QUESTIONS

By signing below, you certify that this procedure has been explained to you and your satisfaction. Any further questions can be directed to a your therapist.

CONSENT

I have reviewed this consent form. My consent and authorization for procedures are strictly voluntary. By signing the informed consent form I grant authority for _____ to perform the requested treatment. The purpose of this procedure, risks, complications, alternative methods of treatment have been fully explained to my satisfaction.

Cosmetic indications for these procedures include but are not limited to cellulite reduction, treatment of problem fat areas, skin tightening, and skin rejuvenation. You may experience increased redness to the area or light abdominal discomfort for up to 12 hours. You will be able to return to normal activities following the treatment. Any photos taken will be used to show the clients progress and may be used in marketing ads.

_____ *initial* I have been informed of the potential risks and side effects of all procedures and treatments including but not limited to redness, swelling, heat sensitivity, pain, increase bowel movements and increased urination. The risks, potential damages and adverse side effects have been explained to me and I fully understand.

_____ *initial* I understand that a minimum of 8 or more treatments may be required to achieve full results. At that point, I will be reevaluated to see if more sessions are needed in order to achieve realistic goals. Each body is different and may require more or less treatments depending on the client's diet, exercise, metabolism and body type. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program.

No guarantee has been given by anyone as to the results that may be obtained by this treatment. I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information and feel I am sufficiently advised to consent to this procedure. I hereby give my consent to have this procedure. If at any time during the procedures I experience pain or discomfort of any kind, I agree to inform the staff immediately and/ or terminate the session at my discretion.

The undersigned assumes all responsibility for behavior of self and their clients and agrees to abide by all Rules and Procedures of the property.

I further state that I am of lawful age and legally competent to sign this aforementioned release; I understand the terms of _____

place the highest priority on the client's right to privacy. We do not disclose identifiable information to any third party without your consent. Further, we do not sell, rent, or otherwise allow the unauthorized outside use of personal information such as names, addresses, phone numbers, or e-mail addresses in our database without your permission. Copies of this form and signature will be valid as if original if this document is digitally scanned.

I am over the age of eighteen and in apparently healthy condition. I understand the above potential risks and benefits of these services. I understand that injury can be unrelated to the technician, instruction or equipment.

I agree to hold _____ not responsible for any claims or negligence.
therapist name

Date: _____

Client Name (Printed) _____

Client Signature _____

Body Measurement Tracking & Treatment Chart

Measure	Visit 1	Visit 1	Visit 2	Visit 2	Visit 3	Visit 3	Visit 4	Visit 4	Visit 5	Visit 5
	Date / /		Date / /		Date / /		Date / /		Date / /	
Chest										
Waist										
Hips										
Weight										
BMI										
BF%										
VF										

Full name

D.O.B. Age

Sessions purchased	
Areas treated	
Price	
Payment plan	
Amount owed	
Payment type	
Final payment date	

PHOTO & VIDEO RELEASE FORM

I, _____ , hereby grant and authorize _____ 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 _____

COVID-19 LIABILITY RELEASE WAIVER

THIS FORM MUST BE COMPLETED AND SIGNED BEFORE TREATMENT

The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions which _____ adheres to comply.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry Cough
- Difficulty Breathing

I agree to the following:

- ☐ I, nor members of my household, have not experienced any of the symptoms listed above within the last 14 days.
- ☐ I, nor members of my household, have not travelled internationally in the last 30 days.
- ☐ I, nor members of my household, do not believe that we have been exposed to someone with a suspected and/or confirmed case of the Coronavirus (COVID-19).
- ☐ I, nor members of my household, have not been diagnosed with the Coronavirus (COVID-19) within the last 30 days.
- ☐ The venue cannot be held liable from any exposure to the Coronavirus (COVID-19) caused by misinformation on this form or the health history provided by each client.
- ☐ I understand that due to the frequency of visits of other clients, the characteristics of the virus, and the characteristics of these services that I have an elevated risk of contracting the virus simply by being in the establishment.

To prevent the spread of the contagious virus and to help protect each other, I understand that I must follow the establishment's guidelines:

- Reschedule appointment if you are feeling unwell;
- No additional guest is allowed;
- Wearing a mask is required upon arrival and during the entire procedure;
- Wash hands upon arrival;
- Limit conversation during the procedure.

By signing below, I agree to each above statement and release the venue and its employees from any and all liability for the unintentional exposure or harm due to Covid-19 and other communicable conditions.

Date: _____

Client Name (Printed) _____

Client Signature _____

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 **not later than 24 hours** prior 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 15 minutes late for an appointment, it will be considered as " 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 _____.

A _____ non refundable deposit will be paid at time of making 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 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 _____

BODY SCULPTING
Pre-treatment advices

How to prepare for your treatment

Drink at least 2L of water the day before treatment

Avoid Alcohol and caffeine or carbonated drinks for at least 24 hours before your treatment

Wear loose fitting clothes on the day of your treatment

Avoid heavy meals the day before and do not eat 2 hours before your treatment

Shave any body hair on and around the area to be treated

Remove any lotion and cream from your skin before treatment

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BODY SCULPTING
Post-treatment advices

What to do after your treatment

- No hot bath or showers
- No saunas, hot tubs or Jacuzzi
- Drink plenty of water
- Avoid alcohol or caffeine for at least 24 hours
- Use an ice pack to reduce swelling, stiffness and bruising
- Do not miss your next appointment
- Maintain a healthy balanced diet and regular exercise is important to maintain the result
- Massage the treated area daily to prevent fat and toxins from becoming stagnant

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