READ CAREFULLY – CONSENT TO TREATMENT

Ultrasound Cavitation Consent For Treatment

Name:_____Email Address: DOB:

Address: City: State: Zip:

Phone: (work) (home) (cell)

Emergency Contact: (name) (phone)

Ultrasound Cavitation Treatments [check all that apply]

____ Arms ____ Upper Back ____ Lower Back ____ Abdomen ____ Waist [love handles] ____ Hips [saddle bags] ____ Buttocks ____ Front of Thighs ____ Back of Thighs [hamstrings] ____ Inner Thighs ____ Calves

Medical Background Check if you answer YES to any of these questions:

Are you pregnant or nursing? o Are you epileptic? o Do you have any kind of tumor or cancer? o Do you have any cardiac or vascular disease or condition? o Do you have any acute inflammation? o Do you have a wound that has not healed? o Do you have current or any history of internal bleeding? o Do you have a pacemaker or other electronic device? o Do you have any plastic or bone cement or any large metal implant? o Have you had any abdomen operations? o Do you have any abnormally high or low blood pressure? o Do you have high levels of Triglycerides (hereditary)? o Are you allergic to zinc or nickel?

o Are you lactose or gluten insensitive? o Do you have hemophilia? o Do you have melanoma? o Do you have thrombosis and / or thrombophlebitis? o Have you undergone a transplant? o Do you have a Neurological disorder? o Are you being treated with anticoagulants? o Do you have any keloid? o Do you have any kind of heart trouble? o Do you have any current infection? o Do you have any infectious disease or tuberculosis? o Do you have advanced untreated diabetes? o Do you have a communicable disease? o Do you have any type of heart, kidney, liver disease? o Any other medical condition? o

If you checked any of the above questions you may not be eligible for treatment. Please explain "Yes" answers here:

_____

_____

Are you presently taking any medications? List: Are you allergic to any foods or medication? List: Please explain any other current medical conditions. Are you taking any vitamins/supplements?: Are you presently under a physician's care? What for? Are you taking recreational drugs?

Family or primary treating physician name and phone number:

Client Signature _____

Date Signed _____

Client Printed Name _____

Accepted by Technician _____

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Disclosure. This treatment is a process and subsequent visits may be necessary in order to achieve the desired results. Subsequent visits are subject to additional charges per visit which depend on the amount of work needed. Actual results vary from person to person and the technician does not guarantee any specific result. The Ultrasound Cavitation treatment carries with it possible health complications and consequences, which include but might not be limited to the risk of kidney failure, liver failure, pacemaker failure, birth defect, miscarriage, thyroid damage, damage to the ovaries, lactation complications, hyper-triglyceridemia, hyper-cholesterolemia, pancreatitis, infection, scarring and/or allergic reaction to any products used, excessive thirst, dehydration, nausea. The Ultrasound Cavitation treatment includes, but is not limited to, the use of high-power low-frequency ultrasound cavitation which uses 25-40KHz frequency ultrasound to penetrate the skin and assist with the breakdown of fat cells by creating micro-bubbles that increase the pressure around the adipocyte and force it to implode, thus breaking down the adipocyte's cell membrane.

After Care. After care instructions must be followed explicitly, whether given in writing or orally. Failure to follow after care instructions may compromise the final results of the treatment.

Before, During and After Pictures. Before, during and after pictures or videos may be taken to document the treatment. These pictures or videos become the technician's sole property and may only be used for its legitimate business purposes.

Release. I recognize that there are certain inherent risks associated with the above-described treatment and I assume full responsibility for personal injury to myself. In exchange for such treatment, I hereby fully release and forever discharge the technician (including its officers, members, owners, employees and agents) from any and all damages, costs, expenses, liabilities, causes of action, claims and demands, of whatever character, in law or in equity, whether known or unknown, direct or indirect, asserted or unasserted, and whether or not on account of myself, the technician, or other third parties, or in any way arising out of the above described treatment I have requested the technician perform. It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to the treatment or services provided by the technician including any spouse or heirs of the client/patient and any children, whether born or unborn. Any legal or equitable claim that may arise from participation in the treatment shall be resolved under the state law.

I agree to indemnify, hold harmless and defend the technician (including its officers, members, owners, employees and agents) against all third-party claims, causes of action, damages, judgments, costs or expenses, including attorneys' fees and other litigation costs, which may in any way arise from the above described treatment I have requested the technician perform.

Arbitration. It is understood that any dispute arising as to malpractice of the Ultrasound Cavitation treatment shall be decided by a neutral arbitrator. Any arbitration proceeding will be governed by the state arbitration statute, the fees for the arbitrator will be split pro-rata among the parties and each party will be responsible for their own attorneys' fees and costs. Any action to collect fees from the client/patient for the treatments performed may be brought in any court located within the state and the prevailing party in such collection action shall be entitled to recover its reasonable attorneys' fees and costs. Filing of any action in any court to collect any fee from the client/patient shall not waive the right to compel arbitration

of any malpractice claim.

By signing this agreement I confirm that I am over the age of 18, I understand that the Ultrasound Cavitation procedure stimulates permanent changes, that such procedure has possible adverse consequences and that the procedure is for cosmetic purposes only. I certify that I have read the above paragraphs, fully understand this consent and procedure form and hereby consent to the indicated procedure(s). This means that I accept full responsibility for these and/or any other complications which may arise or result during or following the Ultrasound Cavitation procedure which is to be performed at my request according to this agreement and I hereby agree to arbitration of any malpractice claim. I further understand that by signing this agreement, I surrender certain legal rights.

Client Signature _____

Date Signed _____

Client Printed Name _____

Accepted by Technician _____

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Financial Policy:

Thank you for selecting us for your cosmetic needs. We are honored to be of service to you.

Fees: All costs are payable in-full prior to initial treatment and are non-refundable. Package price (3 or more sessions) is payable in full at first package visit prior to treatment. Packages once purchased and with first treatment initiated are non-refundable.

Form of Payment: Please be advised that payment for all services is due at the time services are rendered. We require full payment for the visit prior to being seen by our cavitation technician. We accept Check, Credit Card, Debit Card and Cash. All forms of payment are immediately run through an electronic processing system and immediately deposited into the electronic transfer system.

Collection: In the event this account is referred to an agency for collections or if an electronic check is returned, you agree to be responsible for all returned fees and any collection costs, including collection agency and/or attorney fees.

Client Signature _____

Date Signed _____

Client Printed Name _____

Accepted by Technician _____

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Recommendations prior to starting your first session and during treatment process

• Prior to starting your first session and during each 3-day period of treatment, we recommend you drink 2-3 liters of water. Water and hydration is key to this process being effective.

• To maximize the effectiveness of your sessions, it is best to restrict products that impact lymphatic flow during the program. [caffeine, alcohol and sugar in large amounts]

• Always consult with your Physician before beginning any new Health & Diet Program.

• Always inform us if you have a change in health status or experience any unusual symptoms during your program.

• Plan to spend 10 minutes after your session on our in-office whole body vibration machine; this will maximize lymphatic drainage to more quickly flush out cellular waste produced during the session.

• We recommend additional daily exercise to stimulate lymphatic flow. This includes low impact workouts, brisk walking, swimming or cycling during this process. Adding this activity to your ongoing lifestyle will help to stabilize your weight and fat loss.

• You can have Ultrasonic Cavitation during your Menstrual Cycle but it is recommended to avoid the abdomen as you may not see the immediate results, due to bloating.

• We concentrate on treatment of one body area during each session. “Time on Target” will achieve maximum results. Treatments can be done a minimum of 72 hours apart.

• Tell us if your digestive process is affected in any way during a session. [constipation/diarrhea]

• If you should become pregnant during this process please inform us immediately.