Renew LASER & AESTHETICS

eM·Dé CARES

ULTRASONIC CAVITATION + TRIPOLAR RADIO FREQUENCY PATIENT REGISTRATION & CONSENT

Full Name: _____ **Date of Birth:** ____/____/____

Address: _____

Home #: _____ **Cell #:** _____

Email: _____ **Area to be Treated:** _____

IT IS THE CLIENT'S RESPONSIBILITY TO NOTIFY RENEW LASER & AESTHETICS IF YOUR PHONE NUMBER FOR CONFIRMATIONS HAS CHANGED.

Please Circle

Pregnant	YES / NO	Smoking	YES / NO
Diabetes	YES / NO	Cardiovacular Disease	YES / NO
Herpes/ Cold Sores	YES / NO	Any Blood Disease	YES / NO
Histamine (Hives)	YES / NO	Cancer	YES / NO
Epilepsy	YES / NO	Hepatitis	YES / NO
Metallic Implants	YES / NO	Allergies	YES / NO
Prosthetics	YES / NO	Present Illnesses	YES / NO
Keloids	YES / NO	Pace Maker	YES / NO

Other:_____

Present Medications:_____
(Blood thinning medication, Aspirin, Antibiotics, Cortisone, St. John's Wort, Oral Contraceptives, Depression Medication or Mood-Altering Drugs)

Tanning/Sun Exposure: Daily/ Weekly / Monthly**/**Yearly

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. I, the undersigned, declare that I have answered all of the above questions to the best of my ability and knowledge. I will not hold any physician, technician, or any member/staff responsible for any errors or omissions that I may have made in the completion of this form. With full and clear understanding, by signing below I release the technician from liability associated with these procedures.

PATIENT CONSENT

Ultrasonic Cavitation are technologies for breakdown of the fat deposits. These procedures do not involve invasive surgery - there is no need for anesthesia, hospital stay and no down time. They provide a non-invasive method to break down stubborn fat deposits that never seem to disappear no matter what your diet is or how hard you exercise. The most problematic body areas are abdomen, flanks (love handles), inner thighs, buttocks, inner knees, under chin and upper arm.

Appointments are scheduled no less than four (4) days apart. In order to ensure maximum results, it is necessary to follow the recommended treatment schedule. The total number of treatments will vary between individuals. **On occasion, there are patients that do not respond to treatments.** I understand the nature, goals, limitations and possible complications of this procedure and have discussed alternative forms of treatment. I have had the opportunity to ask questions about the procedure, as well as any limitations, complications and/or side effects.

I have read, agree to, and understand the following:

1. The goal of any treatment, as in any cosmetic procedure, is improvement, not perfection, and results may not be perfect due to any genetic, hormonal, nutritional, or topical applications interference or an impact of unpredictable reactions.
2. Individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections. Bacterial, fungal and viral infections can occur. Herpes simplex (viral infections) around the mouth can occur following a treatment. Should any type of skin infection occur, check with your physician for proper treatment.
3. Allergic Reactions: In rare cases, allergies to tape, preservatives used in cosmetics, topical preparations, etc. have been reported. Systemic reactions (which are more serious) may result from prescription medicines.
4. **Compliance with the aftercare guidelines is crucial.**
5. Occasionally, **unforeseen mechanical problems may occur** and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

Do not accept advice from anyone not directly responsible for your post care. Suggestions from friends may be sincere, but are often not helpful or even innocently harmful.

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PRE-TREATMENT INSTRUCTIONS

- Make sure you are hydrated by increasing your water intake, no less than 2 liters.
- Limit your caffeine intake.

POST-TREATMENT INSTRUCTIONS

- Normal activity can be resumed.
- No caffeine (tea, coffee or coke) for at least 48 hours.
- No alcohol (your liver is working to rid your body of extra fat) for at least 48 hours.
- Drink lots of water to help speed up secretion of fat, no less than 2 liters.
- Avoid fatty meals directly after (i.e., fried food, sweets).
- To maintain results, patient must be compliant with a proper diet and increased physical activity.

Should you have any concerns or questions, please do not hesitate to call our office. Our goal is client satisfaction and VERY important to educate our client, so they will fully understand the procedures of Ultrasonic Cavitation have trust, confidence and cooperation in their decision.

ACKNOWLEDGEMENT

I have read and understand all of the above. I have asked any and all questions that I have regarding the procedure of Ultrasonic Cavitation, Tripolar Radio Frequency, **pre-treatment and post-treatment.** I was given written instructions for **post-treatment** care at home. I understand completely and will take full responsibility for post-treatment care. All of the treatment fees have been discussed with me and I understand them completely.

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release **all related staff** from all liabilities associated with the above-indicated procedure. By signing this form, I am giving Renew Laser & Aesthetics permission to treat me, and I understand all symptoms and side effects that may occur during or after treatments, thereby releasing Renew Laser & Aesthetics of all liability regarding these issues.

Should you have <u>any</u> concerns or questions, please do not hesitate to call our office. Our main goal is client satisfaction. That is why it is VERY important to educate our clients so they will fully understand the procedures of Ultrasonic cavitation and have trust, confidence and cooperation in their decision.

We provide each client with full consultation, before treatment, and information of pre and post care necessary to achieve the best results possible.

All clients MUST sign this Consent Form indicating that they have read all of the pre- and post-treatment instructions, which are also discussed during consultation. The consent form is an agreement with the client that he/she is agreeing to be treated and that the client fully understands all pre- and post-treatment instructions as well as possible symptoms and/or side effects and skin reactions that may occur due to treatment. These symptoms and side effects include: diarrhea, headaches, toothaches if client has metal teeth fillings, bruising, ringing in the ears, kidney failure, liver failure (e.g. fatty infiltration of the liver), carrying a pacemaker or other electronic devices, pregnancy, lactation, hypertriglyceridemia, or hypercholesterolemia. These symptoms and side effects are normal and cannot be predicted. All side effects vary with each individual.

I understand that only the physician or technician can decide if treatment is **NOT appropriate** for the following reasons:

- Presence of metallic prosthesis
- Acute inflammatory processes
- Tumors or cancer
- Cutaneous lesions
- Proximity of the organs and the bone marrow
- Pace maker, high blood pressure or heart problems
- Pregnancy / breastfeeding
- Epilepsy
- Metal plates in your body
- Gall stones

- Active infections, hives, herpetic lesions, or cold sores
- Medications
- Extreme sensitivity or allergic reactions in the treated area
- Kidney damage, liver damage or diseases
- Hemorrhagic disease, clotting or bleeding
- Medical plastic parts or parts with meal inside
- Abnormal immune system
- Numb or insensitive to heat

If I mislead the physician or technician for any of the reasons mentioned above, by signing below I fully understand and take responsibility for the post-treatment consequences.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience. Should you have any concerns or questions, please do not hesitate to call our main office line (561) 513-9313.

Initial Please

_____ I have provided my past and current medical history and medications.

_____ I consent to the taking of photographs during the course of my ultrasonic cavitation, radio frequency, laser therapy for healthcare records.

_____ I consent to using my photographs for medical education and/or marketing purposes. My name will not be used to identify these photographs.

_____ I am not pregnant or nursing.

_____ I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the 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 understood all information presented to me before signing this consent form.

_____ I hereby release all related staff from all liabilities associated with the above-indicated procedure.

_____ By signing this form, I am giving Renew Laser & Aesthetics permission to treat me, and I understand all symptoms and side effects that may occur during or after treatments, thereby releasing Renew Laser & Aesthetics of all liability regarding these issues.

_____ **PACKAGE REFUND POLICY**. By signing this No Refund Policy, I am agreeing that any service(s), service package(s), gift certificate(s), and/or retail product I purchase(s) at Renew Laser & Aesthetics is a final sale. I understand any and all services(s), service package(s), gift certificate(s), and/or retail product(s) purchased will not be refunded or issued a credit. I also understand that if I decide to cancel or postpone any service(s), service package(s), gift certificate(s), and/or retail product(s), I will forfeit all monies paid; including any deposits and/or payments I have already paid.

Signature _____ **Date**_____/_____/201____

Print Full Name _____

Signature _____ **Date**_____/_____/201____

Print Full Name _____