NEW CLIENT HISTORY FORM

Full Name:_____Date:_____/_____/_____

Address:_____Birth Date:_____Sex: ☐M ☐F

City:_____State_____Zip Code:_____

Cell Phone:_____Home Phone:_____Work Phone:_____

Email:_____Occupation: _____

How did you hear about us:* (If someone referred you here, please name them so that we may thank that person)
Friend Referral

Social Media (Please indicate which version you used to find out about our office)
☐Facebook ☐Twitter ☐Instagram ☐Facebook ☐Website ☐Other:_____

What is your main area(s) of focus/your problem area(s)

MEDICAL HISTORY

Do you have any chronic medical conditions which we should know about? ☐Yes ☐No
If so, please list:

Do you have any allergies to latex, medications, herbal or natural supplements? ☐Yes ☐No
If so, please list:

Do you have, or have you had, any changes in medical history recently? ☐Yes ☐No
Explain:

Do you have Hearing aids, Pacemaker or Hormone Pellets (where) or metal/medical devices implanted? ☐Yes ☐No Explain:

Do you have type 1 or 2 Diabetes? ☐Yes ☐No
List all current Medications including Vitamins

Do you have or have you had Cancer in the last 12 months? ☐Yes ☐No
If yes, are you currently on chemotherapy? ☐Ye ☐No
Do you have a Thyroid Problem? ☐Yes ☐No

Do you have High Blood Pressure or a Cardiovascular conditions? ☐Yes ☐No

Women Only, are you currently pregnant or nursing? ☐Yes ☐No

Please give us your current Weight_____Height_____

What is your Ethnic Background?_____

Circle which applies to you: ☐Epilepsy ☐Infections ☐Tumors ☐Skin Diseases Loss of

☐Normal Skin Sensation ☐Thrombosis/Phlebitis ☐Autoimmune Disease

☐Neck/Back Problems

Gallbladder Removed ☐Yes ☐No

History of Gallstones ☐Yes ☐No

History of Liver Problems ☐Yes ☐No

Are you currently dieting? ☐Yes ☐No

Explain

History of Colon problems including protruding/distended belly? ☐Yes ☐No

Explain:

Have you had any surgeries? ☐Yes ☐No

Typical Daily foods and drink intake?

☐Water: How Many Glasses _____ ☐Coffee: How many cups_____

☐Alcohol: How Much_____

☐ Fast Food: type_____ ☐Soda or Carbonation: Type_____

How Often_____/_____ How Often_____/_____

☐Tobacco Use_____/_____ ☐Recreational Drugs (narcotics)

Stress Level: ☐Moderate ☐Average ☐Demanding

I, (print name)_____, consent to allow the staff members to consult with & evaluate me in order to determine if I am a good candidate for the Non-surgical Body Contouring Program. I understand that photographs and measurements will be taken and kept in my file.

I agree that these forms have been completed truthfully and to the best of my knowledge/abilities.

Signature_____Date_____

(if minor, parent's signature)

CONSENT FORM

Body sculpting increases flow of both the lymphatic and circulatory systems, and it also helps with cleaning of the tissues. The main use of body sculpting treatment is inch loss, diminishing of cellulite, and tightening of the skin.

Benefits:
Lose 1-3 inches per treatment with state-of-the-art equipment. Benefits are often immediate, but may be delayed in some people.

For Best Results:
A series of 9-12 body sculpting treatments are recommended per each area, but some individuals may require more treatments to achieve maximum results. There should be at least 1-2 days between each treatment. This is not a weight loss treatment, but an inch loss. The inches will only return if the client goes back to their old habits. Eating the right types of food, proper exercise, and drinking 8 glasses of water per day are always recommended. For best results, it is recommended that you exercise within 4-6 hours of treatment and avoid sugar and alcohol for 24 hours after each treatment.

Precautions:
Body sculpting treatments are not recommended if you are pregnant, breast feeding, have a lymphatic disorder, acute illness, metal implants, pacemakers, or are currently being treated for active cancer.

Waiver:
I understand that I am using the Relaxed Fitness Vibration 360 machine provided at my own risk. Should I sustain an injury while using the equipment, I agree to not hold Bthe service provider responsible.

Acknowledgement:
I understand and acknowledge that payments for the above services are non- refundable. By my signature below, I certify that I have read and understand the contents of this Consent Form for Body Contouring. I further agree to provide 24- hour notice of a cancellation or change in appointment time, or I will forfeit a treatment off my package since treatments are by appointment only. There are no refunds if I am responding to treatment and decide to stop treatments. Should I decide to add an Ultrasound treatment and/or a Radio Frequency treatment, that treatment will be considered an additional and separate treatment. This extra treatment can be paid for separately or deducted from the number of treatments in my Cold Laser package. Should the service provider wish to use any photos of my progress other than for my personal file, I will sign a separate Photo Release form.

Client Signature Date

CANCELLATION POLICY

If there is a need to cancel for any reason, we ask for a 24-hour notice. Please understand that when you do not cancel or show up for an appointment, it is a cost to us. If you cannot provide us with a 24-hour notice, we may impose the following fees:

“No Show” for session:

*Loss of that treatment in your treatment package

Same day cancellation:

*$50.00 charge before your next scheduled treatment

I,_____, have read and understand the cancellation policy of the service provider and agree to abide by the above conditions.

Signature Date

TERMS OF ACCEPTANCE/INFORMED CONSENT

Please read carefully and understand the contents of this form. Ask us if you not understand.

When a client seeks Body Contouring services and when the service provider accepts a client, it is essential that both are seeking and working for the same goals. We expect our clients to take full responsibility for their decisions to participate in any of the services/programs offered by this office. We do not identify, diagnose, or treat ANY condition or disease. We have only one goal: **TO OPTIMIZE YOUR BODY'S ABILITY TO FUNCTION NORMALLY AND OPTIMIZE YOUR FAT-BURNING POTENTIAL.** By reducing bio-stress levels, we allow the body's inborn self-correcting mechanism to work at maximum efficiency to restore, maintain and promote wellness.

We do not identify or diagnose any condition(s) or disease(s). We offer no treatment for any condition(s) or disease(s). We promise no cure from any disease(s) or condition(s). Instead, we facilitate your body's own self-correcting mechanism.

It is essential that you speak to your doctor prior to making any decisions about altering any medical regimen you are currently following, changing your diet, taking supplements, or going on an exercise and/or weight loss program. Getting your doctor's approval prior to starting any service/program at our office is critical and solely your responsibility. Should any health condition arise while you are a client, we recommend that you immediately see the appropriate health care provider.

Any options that are rendered by the staff and/or head personnel should **NEVER** be construed as medical advice but merely as opinions. If you like medical advice, please see one of our medical doctors. **We will not deal with any medical condition.**

With your signature below, you understand and voluntarily accept these risks and agree that neither the service provider, its staff, or any of its partners will be liable for any injury to you, including, but not limited to, personal bodily injury, death, mental injury, economic loss or any damage to you, your spouse, or relatives resulting from any act of Bthe service provider, and its staff or anyone else using the facilities and that you acknowledge the inherent risks of the positions, movement, dietary/nutritional programs offered to and done to you at the service provider, with respect to your current or past condition(s). If there is any dispute between you and the service provider, and/or any of its staff, both parties agree to submit it to binding arbitration. We both agree to have a neutral arbitrator preside over any such dispute, not a judge or jury.

I, the undersigned, understand and accept the conditions as laid out in the “Terms of Acceptance” above.

Client Signature Date

Office Acceptance by:

SERVICE AGREEMENT

The following provisions apply to the services to be performed for_____.
(Client Name)

1 SERVICES TO BE PROVIDED

The Office provides ultrasound, laser, and radio frequency treatments. _____(Initials)

2 PAYMENT

Payment in full is to be made prior to the start of any program. _____(Initials)

3 CLIENT COOPERATION

This Agreement contemplates full Client cooperation in the course of services agreed upon. This cooperation includes Client's agreement to remain active in the recommended program for_____body contouring visits. The Client recognizes that compliance with recommended services and service schedule is important and the Client agrees to follow the service plan and the course of treatment agreed upon. The Client understand that lack of cooperation, failure to keep appointments and engaging activities identified by the office as potentially counterproductive to the body may necessitate additional treatments to those otherwise provided for this Agreement. **Our office policy requires 24-hour advance notice for appointment cancellation. Failure to do so may result in deduction of pre-paid visits.** _(Initials)

4 TERMINATION

Subject to the provisions of paragraphs 5 and 6 of this Agreement, the Client may discontinue care and terminate this Agreement at any time by written notice to that effect delivered in person, or by mail, to the office. Such "notice of termination" shall discharge the office from all further obligations and/or duty to render care to the client. The office reserves the right to terminate this Agreement in its sole discretion notwithstanding any other terms or provisions of this Agreement. ` _____(Initials)

5 NO REFUNDS IN THE EVENT CLIENT TERMINATES AGREEMENT

To encourage commitment and follow-through, the service provider offers **no refunds**. No refunds will be made on body contour treatments. There will be **no exceptions**. The prepaid program cannot be altered, shared or transferred, nor can it be combined with any other program. _____(Initials)

6 NO GUARANTEE OF RESULTS

Client recognizes that neither Office personnel nor this Agreement provides a guarantee of results. The Office makes **no guarantee** of the extent or longevity of improvement to be expected. This Agreement deals solely with the services to be rendered and the fees to be paid for the care as provided. The Client's payment obligation is not contingent upon the outcome of services. Client's results can be hindered and/or suppressed by the consumption of the following, but are not limited to, alcohol, processed foods including, but not limited to, sugar-based foods and drinks, etc. It is recommended to consult your physician for dietary modification clearance if you have any questions or concerns.

7 TIME LIMITATION FOR SERVICES

Client understands that unused visits will expire if not used within 120 days from the date Client starts the treatment unless the Office has been provided with advance notice in writing of leave of absence or other cause of delay. After 24 weeks, all outstanding services/visits will be void. _____(Initials)

8 RELEASE OF LIABILITY

Client agrees to indemnify, hold harmless and release the service provider, its agents, employees, officers, directors, representatives, assigns, members, affiliated organizations, and insurers, and others acting on the Company's behalf, of all claims, demands, causes of action, and legal liability, whether the same be known or unknown, anticipated or unanticipated, and further agrees that except in the events of the Company's gross negligence or willful and wanton misconduct, no claims, demands, legal actions and causes of action, shall be made against the Company for any economic and non-economic losses of any kind.

_____(Initials)

9 YOUR RESPONSIBILITIES

1. Keep your appointments. We require 24-hour advance notice to reschedule/cancel an appointment.
2. Follow your program as closely as possible. Report any deviations to the Office staff so that we can help you get back on track.
3. If you have any challenges whatsoever, please share them with us immediately. Remember, it is in both our interests for you to succeed in achieving your goals.
4. If you have any medical conditions, please share this program with your physician immediately. The service provider is not a medical facility and does not make medical decisions.

_____(Initials)

10 GOVERNING LAW

This Agreement shall be governed, construed and interpreted by, through and under the Laws of the State of _____.

11 COMPLETE AGREEMENT

This Agreement constitutes the complete agreement and understanding between Client and Office and will not be changed or modified in any way unless agreed to by both parties in writing. _____(Initials)

THE CLIENT HAS FULLY READ THIS AGREEMENT AND ANY SUPPLEMENT HERETO, AND UNDERSTANDS AND AGREES TO ABIDE BY ALL OF THE TERMS HEREOF.

Client Name **Date**

Client Signature

OFFICE ACCEPTANCE:

BY: **Date**