Melt That Fat Away

(Please Print Clearly)

Your Name:	Referred by:	Today's Date:	
Address:	City:	State:	Zip:
Home #:	Work #:	Cell #:	
Email Address:			
Height: Weight:	Date of Birth:	Age:	Sex:
Marital Status:	Are you pregnant? ❑ No ❑ Yes, how far along?		
How much water do you consume per day?			
Occupation:	How many hours per week do you work?		
Are you currently under the care of a physician? ❑ No ❑ Yes, for what reason(s):			
How stressed are you? (On a scale of 1 to 10, where 10 is the worst):			
Have you ever had any health conditions that affected your liver? ❑ No ❑ Yes, explain:			
Have you ever had cancer? ❑ No ❑ Yes, explain:			
Do you exercise? ❑ No	❑ Yes, how often?	What type?	
Which do you want us to focus on? ❑ Abdomen ❑ Buttocks ❑ Thighs ❑ Chest ❑ Arms ❑ Neck ❑ Cellulite			
How long have you been overweight?			
How much weight do you want to lose?			
Are you embarrassed about your weight/appearance? ❑ No ❑ Yes, explain:			
How important is weight or size reduction to you? (On a scale of 1 to 10, where 10 is the most important)			
Are other members of your family overweight? ❑ No ❑ Yes			
Do you feel tired, run down, or out of energy? ❑ No ❑ Yes, explain:			

I clearly understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment.

Your Name (print): _____

Signature: _____ Date: _____

---------- DO NOT WRITE BELOW THIS POINT ----------

Provider's Notes:

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Patient's Name: _____

Date of Initial Evaluation: _____

Height: _____

Weight Starting: _____

Weight Goal: _____

Inches Off Goal: _____

Weight	
Body Fat Percentage	
BMI	
Muscle %	
Resting Metabolism	
Visceral Fat	
Body Score	

Comments:

	1st Visit		4th Visit	8th Visit	12th Visit
Weight					
Biceps (Right)					
Biceps (Left)					
Thigh (Right)					
Thigh (Left)					
Abdomen (Umbilicus)					
Abdomen (2" Above)					
Abdomen (2" Below)					
Hips/Buttocks					
Chest					

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Informed Consent and Release of Liability Form

Name: (First)_____ (Last)_____DOB_____

Program and Background
You have requested treatment utilizing Lipo-Melt LED light therapy. This treatment is the application of a 635 nm light, which causes fat within the adipose (fat) cell to leave and accumulate in the interstitial space. This excess fat is removed by the body's lymphatic system and excreted without negative side effects or downtime. Any medical or cosmetic procedure carries risks, complications and varied results. The purpose of this document is to inform of the nature of this product and it's risk. LED therapies have been approved by the FDA.

Procedure
Initially you will consult with a Lipo-Melt therapist to determine if you are a candidate for the LED therapy. 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 this procedure, then paperwork, measurements, pre and post treatment photos (upon your approval) and suggested course of treatment will be given. The treatment is administered by placing up to 4 LED pads on the desired area(s) to be treated. Most patients will need a minimum of 9 – 12 treatments for the Light LED therapy to achieve its desired effect. This treatment should be used in conjunction with a healthy diet and exercise. You should consult a health care professional before beginning any new exercise program to determine if your body is physically able.

Risks/Discomfort
This treatment is non-invasive. During treatment there should be no discomfort. The client may feel the warmth of the light. Lipo-Melt is suitable for anyone over 18 who does not have any of the following issues:

Pregnancy, Breast Feeding, Kidney or Liver Disease, Recent Cancer, Heart Disease, Pacemaker, Autoimmune Disease, Metal Pins or Plates, Thyroid Problems or Urine Infection.

Benefits
LED light therapy has become more prominent and has been used in many studies for pain management and recently by cosmetic surgeons to emulsify adipose before liposuction with FDA approval. 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 their stomach, hips, and thighs. These results vary and no guarantee is implied or suggested that desired results will be achieved.

Voluntary Cosmetic Procedure

_____(Initial) I understand that this is a strictly voluntary cosmetic procedure. No treatment is necessary or required and the Lipo-Melt LED therapy has been chosen by myself (the client).

_____(Initial) I have been informed of the potential risks and side effects of Lipo-Melt 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 them.

_____(Initial) I understand that a minimum of 9 - 12 treatments is required to achieve results at an average BMI of 25 to 30. A BMI of over 30 (which is considered in the obese range) requires a specific strategy moving forward with the minimum recommendation of 24 + treatments. 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.

_____(Initial) I know that if after the treatment program I gain weight, the results of the Lipo-Melt may be reversed.

_____(Initial) I understand that no guarantee has been given 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 herby give my consent to have this procedure. If at any time during the Lipo-Melt procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/ or terminate the session at my discretion.

_____(Initial) I duly authorize technicians to perform the procedure for the purpose of body contouring, lymphatic drainage, improvement of cellulite and skin tightening. I am aware that clinical results may vary depending on individual factors, medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. If I do not make an effort to address my diet and exercise, the results achieved may not be retained.

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_____(Initial) I have reviewed this consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form I grant authority to perform the described 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. Increased redness to the area for up to 12 hours may be experienced (although this is unlikely). Normal activities may be resumed following the treatment. Any photos taken will be used to show the clients progress and may be used in marketing ads.

Questions and Explanations
By signing below, you certify that this procedure has been explained to you and that you have been fully informed of the nature and purpose of the Lipo-Melt procedure, expected outcomes and possible complications, and understand that no guarantee can be given as to the final results obtained. You are fully aware that your condition is of a cosmetic concern and that the decision to proceed is solely based upon your expressed desire to do so. You are aware that Lipo-Melt may/can cause slight hypo/hyper–pigmentation of the skin and treatment is taken at your own risk (tattoo areas should be avoided). Any further questions can be directed to a Lipo-Melt Specialist. Furthermore you are of lawful age and legally competent to sign this aforementioned release, and that you understand the terms herein is contractual and not a mere recital; You have signed this document of your own free will.

Whole Body Vibration Plate Exercise Risks
Whole Body Vibration Plate Machines are scientifically calibrated exercise machines designed to force your muscles to stretch and contract rapidly in small increments, replicating the same action which occurs during traditional exercising. Vibration exercises use your body weight and gravity to it's fullest potential. Please do not use a whole body vibration plate or any other exercise device without getting approval from your doctor.

The device is not recommended if you are: pregnant, diabetic with complications such as neuropathy or retinal damage, have a pacemaker, recently underwent surgery, suffer from Epilepsy or Migraines, have herniated disks, spondylolisthesis, spondylolysis , have cancer or tumors, have recent joint replacements, have metal pins or plates, or have any other concerns about your physical health. These contra-indications do not mean that you are not able to use a vibration or other exercise device, but it is recommended that you consult your physician first.

_____(Initial) I understand that using a whole body vibration machine workout is a strictly voluntary physical activity chosen by myself (the client). If at any time I experience pain or discomfort of any kind, I agree to inform the staff immediately and/or terminate the exercise.

OUR PRIVACY POLICY

We value your privacy, and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. 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. If any part of this Release is found to be invalid by the courts having jurisdiction, or becomes inoperative for any reason, such invalidity shall not affect the validity and enforceability of any other provision of this release.

POLICIES AND TERMS AGREEMENTS

Cancellation Policy
We require a 24 hour cancellation notice.
* If I cancel within 24 hours of a reserved session, I will lose or forfeit my session
* If I cancel within 24 hours of a reserved session, I might incur a $35 no-show fee

If I fail to show up or am more than 5 minutes late, I will lose or forfeit my session due to staff wages and fees paid for my session. Our cancellation policy has been created to ensure that our loyal clients are not disturbed by the tardiness of clients who do not show up on time, or who cancel within 24 hours of an appointment. When reserved sessions are unattended, this means that loyal clients missed the opportunity of having that particular time period.

Purchase and Reservation Policy
Sessions will only be confirmed and allowed up to the amount of pre-paid sessions. All sales are final and non-refundable. We reserve the right to terminate any client's session, package, or contract, without refunding any monies if the client has broken any terms or policies. All purchases are final, non-refundable and non-transferable.

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* I understand if I have purchased and pre-paid for a first-time customer promotion, that I may not use or purchase another first-time promotion without consent. I further state that I am of lawful age and legally competent to sign this aforementioned release. The procedures, alternatives and risks have been explained to me and I have been given the opportunity to ask questions. I understand it is my responsibility to inform the staff is there are any changes to my medical history. I understand the terms herein is contractual and not a mere recital. I have signed this document of my own free act.

I HAVE CAREFULLY READ, UNDERSTOOD AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS.

Client's Name	Client's Signature	Date
Staff Member's Name	Staff Member's Signature	Date

First Name | Middle Name / MI | Last Name

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to afl claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial below. Effective as of the date of first professional services.

Initials

_____

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If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that J have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION. AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.