First Name:_____ Last Name:_____

Client Treatment Chart

I confirm the following, please initial each statement:

I am over the age of 18	____	I have no known liver or kidney disorders	____
I am not pregnant or lactating	____	I have no known thyroid gland dysfunction	____
I do not have epilepsy	____	I do not have a compromised immune system	____
I do not have Herpes Simplex	____	I do not have cancer or a history of cancer	____
I do not have uncontrolled Hypertension	____	I am not taking drugs that cause photosensitivity	____
I do not have a pacemaker	____	I have no known photosensitivity to sun exposure	____

I do not have unusual emotional or psychological reaction to any treatment/procedure including but not limited to cold laser treatment _____

Past Surgeries or Major Illnesses:_____
Medications currently taking:_____

Limitation to Treatment

I understand there are no guarantees as to the results of this treatment.
I understand that to achieve maximum results, I may require several treatments.
I understand that an appropriate diet and regular exercise will assist to sustain and create a cumulative degree of overall spot fat reduction and body contouring.

Risks

I have been informed and I understand that temporary hyperpigmentation/hypopigmentation on rare occasion may occur as a result of treatment.
I hereby certify that all information that I have provided has been accurate and truthful.
I hereby authorize BEAUTY EQUALS HEALTH to perform Laser Lipo for the purpose of aesthetic body contouring and girth loss.

Street Address:_____ City:_____ State: _____Zip Code:_____

Home/Cell Phone:_____ Email:_____

Client Signature:_____ Date:_____