

Laser Lipo Consent and Release Form

Name: (First) _____ (Last) _____ DOB _____

A. Program and Background

You have requested to be treated with the Laser Lipo low-level laser therapy manufactured by Matrix. This treatment is the application of a 635nm low intensity laser, which has been shown through extensive research to cause the fat within the adipocyte (fat cell) to leave the cell and accumulate in the interstitial space around the cells. In contrast to high-power, high heat lasers that are used in various medical procedures, the low level laser used for this treatment has no thermal effect on tissue. Instead, the non-invasive laser helps the body absorb fat by stimulating its biological function. Excess fat is then removed naturally by the body's lymphatic system and subsequently excreted without the negative side effects and downtime associated with more invasive procedures such as liposuction. This therapy has been tested in several institutional review board approved studies in a double blind; placebo controlled fashion and found to be generally effective. Any medical or cosmetic procedure carries risk, complications and varied results as to the effectiveness of a particular treatment. The purpose of this document is to make you aware of the nature of this product and its risks in advanced so that you can decide whether to go forward with this procedure.

Non-invasive low level laser therapy has been approved by the FDA.

B. Procedure

Initially you will consult with the doctor to determine if you are a candidate for low level laser therapy. During this time period you will have the opportunity to ask questions or voice concerns you may have concerning this treatment. If it is determined you are a candidate for this procedure, there will be a few preliminary steps consisting of: paperwork, and measurements. Proceeding, the patient will need to expose the area to be treated and lie down. From here the treatment will be administered by placing 2-4 635nm low level laser paddles on the desired area(s) to be treated.

It is recommended that a patient will need a minimum of six treatments for the low level laser to achieve its potential effect. This treatment should be used in conjunction with a healthy diet and exercise. If you are not currently exercising you should consult a health care professional before beginning an exercise program to determine if your body is physically able.

C. Risks/Discomfort

There are few risks associated with low level laser therapy. This treatment is non-invasive and uses a cold output laser.

During treatment no discomfort will be present, the patient will not feel the laser, however the light will be visible.

*Please inform us if you think you are pregnant, or are unsure if you may be pregnant, as a pregnancy test may be required to proceed with treatment. Although no known detrimental risks exist, potential unknown risks may exist. If you have a pacemaker, this treatment may not be right for you. It is recommended that one does not treat directly over a pacemaker or its lead wires. No known risks exist, however potential unknown risks may exist. There are also a variety of other conditions for this treatment. It is possible that you may not see any improvement in your body shape or it may get worse.

There also may be unknown risks associated with low-level laser therapy.

D. Benefits

Over the years the benefits of low-level laser therapy have become more prominent. Low-level laser therapy has been used by chiropractors 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 4.5 inches lost from there stomach, hips, and thighs. These results do vary and no guarantee is implied or suggested that desired results will be achieved.

E. Alternatives

This is strictly voluntary cosmetic procedure. No treatment is necessary or required. Alternative treatments, which vary in sensitivity, effect, duration, and invasiveness include: liposuction, mesotherapy, lipodissolve, velasMOOTH, dieting, exercise and potential others; which may have their own risks and benefits. You acknowledge this, and realize that the other option to you is do nothing.

F. Questions

By signing below, you certify that this procedure has been explained to you and your satisfaction. Any further questions can be directed to BEAUTY EQUALS HEALTH.

G. Consent

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 for BEAUTY EQUALS HEALTH to perform the described treatment or administer any related treatment as deemed necessary or advisable for my medical condition. 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. You may experience increased redness to the area for up to 12 hours. You will be able to return to most normal activities following the treatment.

I have been informed of the potential risks and side effects of Laser Lipo including but not limited to redness, swelling, heat sensitivity, pain, increase bowel movements, increased urination, increased menstrual flow and flu like symptoms. the nature of the proposed procedure. The risks, potential damages and adverse side effects have been explained to me and I fully understand.

_____ **Initial**

I understand that a minimum of 6 treatments is required to achieve full results. At that point I will be re-evaluated to see if more sessions are needed in order to achieve realistic goals. Patients who are extremely thin may require fewer treatments, while heavier patients may require more. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program. I know that if after the treatment course I gain weight, the results of the Laser Lipo may be reversed.

_____ **Initial**

No guarantee has been given by anyone 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 hereby give my consent to have this procedure.

If at any time during the Laser Lipo procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/ or terminate the session at my discretion.

The undersigned assumes all responsibility for behavior of self and their clients and agrees to abide by all Rules and Procedures of the property.

Clients are responsible for the completion and timely return of any client forms and payments, including but not limited to new client intake forms.

The clients and all persons on the premises by invitation of the clients hereby hold BEAUTY EQUALS HEALTH, its employees, the corporation or any individual connected in any way to BEAUTY EQUALS HEALTH, harmless for any responsibility or liability for any accident, injury illness or damages sustained by or to any person or their personal property during their treatment appointments or use of facilities. BEAUTY EQUALS HEALTH shall be indemnified and held harmless by the clients,

and clients agree to pay all costs incurred in connection with any accident, injury illness or property damage loss, including attorney's fees, regardless of how it may have occurred.

The undersigned hereby releases and indemnifies BEAUTY EQUALS HEALTH and holds harmless any employee, the corporation or any individual connected in any way to BEAUTY EQUALS HEALTH for any loss of personal property and/ or accident causing personal injury of any nature, including reasonable attorney's fees and court costs in connection therewith.

However, in the event of an occurrence, the client should inform our team members who will do everything within reason to rectify the problem.

All information regarding the procedure is checked to ensure the accuracy of descriptions. However, we are not always able to control all of the components of the facility, city power outages, etc., and it is possible that an appointment time or procedure may become unavailable due to circumstances beyond our control and for which we do not accept liability.

I further state that I am of lawful age and legally competent to sign this aforementioned release; I understand the terms herein is contractual and not a mere recital; I have signed this document of my own free act.

At BEAUTY EQUALS HEALTH we place the highest priority on the client's right to privacy. We recognize the added sensitivities for client's receiving body sculpting therapy. Our office staff is trained to protect our private health information, and our waiting areas are intentionally shielded and discrete.

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.

REFUND POLICY

If you purchase additional Laser Lipo treatment(s) and do not wish to use your purchase, we will gladly give you a refund of your purchase price minus a processing fee of \$35.00.

PHYSICIAN and or LASER TECH ESTHETICIAN

I have explained the procedure, alternatives, and risks to the person or persons whose signature is affixed below. The patient has verbally communicated to me that they understand the contents of this form.

Signature of Physician/LASER TECH ESTHETICIAN

Date

PATIENT CERTIFICATION

By signing below I state that I am 18 years of age or older, or otherwise have authorized to Consent the above information. I have read or have had explained to me the contents of this form. I understand that information on this form and give my consent to what has been explained to me.

I authorize BEAUTY EQUALS HEALTH to perform my treatment:

Print Name: _____

Signature: _____ Date: _____