

# The Body Bar Body-Sculpting & MediSpa

## Ultrasound Cavitation and RF Treatment Agreement

Name:	Email Address:	DOB:	
Address:	City:	State:	Zip:
Phone: (work)	(home)	(cell)	
Emergency Contact: (name)		(phone)	

**Ultrasound Cavitation and RF Treatments** Check all that apply:

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Abdomen     | <input type="checkbox"/> Upper Legs “Saddle Bags” | <input type="checkbox"/> Lower Legs (Hamstring Area) |
| <input type="checkbox"/> Inner Thigh | <input type="checkbox"/> Arms (tricep side)       | <input type="checkbox"/> Back                        |
| <input type="checkbox"/> Buttocks    | <input type="checkbox"/> Calf                     | <input type="checkbox"/> Flanks “Love Handles”       |

**Fees.** All costs are payable in-full prior to initial treatment and are non-refundable. Costs do not include future visits unless expressed otherwise. Must pay for entire package price (1, 3, or 6 sessions) on first visit to receive package discount. Packages once purchased and treatment initiated are non-refundable.

**Medical Background.** Check if you answer **YES** to any of these questions:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Are you pregnant or nursing?</li> <li><input type="checkbox"/> Are you epileptic?</li> <li><input type="checkbox"/> Do you have any kind of tumor or cancer?</li> <li><input type="checkbox"/> Do you have any cardiac or vascular disease or condition?</li> <li><input type="checkbox"/> Do you have any acute inflammation?</li> <li><input type="checkbox"/> Do you have a wound that has not healed?</li> <li><input type="checkbox"/> Do you have current or any history of internal bleeding?</li> <li><input type="checkbox"/> Do you have a pacemaker or other electronic device?</li> <li><input type="checkbox"/> Do you have any plastic or bone cement or any large metal implant? Do you have a IUD? WHERE? _____</li> <li><input type="checkbox"/> Have you had any abdomen operations?</li> <li><input type="checkbox"/> Do you have any abnormally high or low blood pressure?</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Do you have hemophilia?</li> <li><input type="checkbox"/> Do you have melanoma?</li> <li><input type="checkbox"/> Do you have thrombosis and / or thrombophlebitis?</li> <li><input type="checkbox"/> Have you undergone a transplant?</li> <li><input type="checkbox"/> Are you being treated with anticoagulants?</li> <li><input type="checkbox"/> Do you have any keloid?</li> <li><input type="checkbox"/> Do you have any kind of heart trouble?</li> <li><input type="checkbox"/> Do you have any current infection?</li> <li><input type="checkbox"/> Do you have any infectious disease or tuberculosis?</li> <li><input type="checkbox"/> Do you have advanced untreated diabetes?</li> <li><input type="checkbox"/> Do you have a communicable disease?</li> <li><input type="checkbox"/> Do you have any type of heart, kidney, liver disease?</li> <li><input type="checkbox"/> Do you have Diabetes?</li> </ul> |
|--|---|

IF YOU ANSWERED “YES” TO ANY OF THESE QUESTIONS **YOU MAY NOT BE ELIGIBLE FOR THE TREATMENT.** Explain any Yes answers:

\_\_\_\_\_

Are you presently taking any medications? List: \_\_\_\_\_

Are you allergic to any foods or medication? List: \_\_\_\_\_

Please explain any other current medical conditions. \_\_\_\_\_

Are you taking any vitamins/supplements: \_\_\_\_\_

Are you presently under a physician’s care? What for? \_\_\_\_\_

Are you taking recreational drugs? What for? Which ones? \_\_\_\_\_

Please list your family or primary treating physician name, phone number, and last time labs were taken:

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**Disclosure.** This treatment is a process and subsequent visits may be necessary in order to achieve the desired results. Subsequent visits are subject to additional charges per visit which depend on the amount of work needed. Actual results vary from person to person and Dream Body Sculpting and Salon Lofts Group, LLC N 5<sup>th</sup> Street Suite 530 Columbus OH 43215 does not guaranty any specific result. The Ultrasound Cavitation and RF treatment carries with it possible health complications and consequences, which include but might not be limited to the risk of kidney failure, liver failure, pacemaker failure, birth defect, miscarriage, thyroid damage, damage to the ovaries, lactation complications, hypertriglyceridemia, hypercholesterolemia, pancreatitis, infection, scarring and/or allergic reaction to any products used, excessive thirst, dehydration, nausea. The Ultrasound Cavitation and RF treatment includes, but is not limited to, the use of high-power low-frequency ultrasound cavitation which uses 25-28KHz frequency ultrasound to penetrate the skin and assist with the breakdown of fat cells by creating micro-bubbles that increase the pressure around the adipocyte and force it to implode, thus breaking down adipocyte's cell membrane along with high intensity heat radiofrequency that penetrates deep below the muscle to stimulate the collagen of the body.

**After Care.** After care instructions must be followed explicitly, whether given in writing or orally. Failure to follow after care instructions may compromise the final results of the treatment.

**Before, During and After Pictures.** Before, during and after pictures or videos may be taken to document the treatment. These pictures or videos become Dream Body Sculpting and Salon Lofts Group, LLC N 5<sup>th</sup> Street Suite 530 Columbus OH 43215 sole property and may only be used for its legitimate business purposes.

**Release.** I recognize that there are certain inherent risks associated with the above-described treatment and I assume full responsibility for personal injury to myself. In exchange for such treatment, I hereby fully release and forever discharge Dream Body Sculpting and Salon Lofts Group, LLC N 5<sup>th</sup> Street Suite 530 Columbus OH 43215 (including its officers, members, owners, employees and agents) from any and all damages, costs, expenses, liabilities, causes of action, claims and demands, of whatever character, in law or in equity, whether known or unknown, direct or indirect, asserted or unasserted, and whether or not on account of myself, Dream Body Sculpting and Salon Lofts Group, LLC N 5<sup>th</sup> Street Suite 530 Columbus OH 43215 or other third parties, or in any way arising out of the above described treatment I have requested Dream Body Sculpting and Salon Lofts Group, LLC N 5<sup>th</sup> Street Suite 530 Columbus OH 43215 to perform. It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to the treatment or services provided by Dream Body Sculpting and Salon Lofts Group, LLC N 5<sup>th</sup> Street Suite 530 Columbus OH 43215 including any spouse or heirs of the client/patient and any children, whether born or unborn. Any legal or equitable claim that may arise from participation in the treatment shall be resolved under Georgia law.

I agree to indemnify, hold harmless and defend Dream Body Sculpting and Salon Lofts Group, LLC N 5<sup>th</sup> Street Suite 530 Columbus OH 43215(including its officers, members, owners, employees and agents) against all third-party claims, causes of action, damages, judgments, costs or expenses, including attorneys' fees and other litigation costs, which may in any way arise from the above described treatment I have requested Dream Body Sculpting and Salon Lofts Group, LLC N 5<sup>th</sup> Street Suite 530 Columbus OH 43215 to perform. **Arbitration.** It is understood that any dispute arising as to malpractice of the Cavitation AND RF treatment shall be decided by a neutral arbitrator. Any arbitration proceeding will be governed by Georgia's arbitration statute, the fees for the arbitrator will be split pro-rata among the parties and each party will be responsible for their own attorneys' fees and costs. Any action to collect fees from the client/patient for the treatments performed may be brought in any court located in Georgia and the prevailing party in such collection action shall be entitled to recover its reasonable attorneys' fees and costs. Filing of any action in any court to collect any fee from the client/patient shall not waive the right to compel arbitration of any malpractice claim. **By signing this agreement I confirm that I am over the age of 18, I understand that the Ultrasound Cavitation and RF procedure is permanent, that such procedure has possible adverse consequences and that the procedure is for cosmetic purposes only. I certify that I have read the above paragraphs, had the procedure and risks explained to me, fully understand this consent and procedure form and herby consent to the indicated procedure(s). This means that I accept full responsibility for these and/or any other complications which may arise or result during or following the Ultrasound Cavitation and RF procedure which is to be performed at my request according to this agreement and I herby agree to arbitration of any malpractice claim. I further understand that by signing this agreement, I surrender certain legal rights.**

Client/Patient \_\_\_\_\_ (signature)

Date Signed \_\_\_\_\_

Accepted by Technician \_\_\_\_\_

Date Signed \_\_\_\_\_

**(Prior to starting your first session and during treatment process)**

**RECOMMENDATIONS:**

- Prior to starting your first session and during each 3-day period of treatment we recommend you drink 2-3 liters of water. Water and hydration is key to this process being effective.
  - To maximize the effectiveness of your session, it is best to restrict products that impact lymphatic flow i.e. caffeine, alcohol and sugar in large amounts during the process.
  - We recommend eating a healthy diet to enhance the process. If you are on one of our specialized nutrition/diet loss plans you are all set. If not we can provide a recommendation sheet for ideal eating during the process, if you to maximize results.
  - We recommend exercise to stimulate lymphatic flow. This includes trampoline, rebounding, swimming, jogging, working out during this process. Even walking will help.
  - We recommend lymphatic massage and detoxification to optimize and enhance the process. Lymphatic massage helps facilitate to removal and release of toxins and fat as you go through the Ultrasound Process.
  - We recommend no more than one body area per lymphatic area and maximum of 30 min of ultrasound time for maximum results.
  - We recommend with Radiofrequency (RF) that you avoid the sun for 1 week and use 25 or more SPF to protect your skin following use of RF especially for face.
  - **IF YOUR DIGESTION PROCESS IS IMPEDED IN ANY WAY DURING SESSIONS LET US KNOW I.E. CONSTIPATION.**
  - Please always discuss with your Physician before beginning any new Health & Diet Program. Always inform us if you have a change in health status or experience any unusual symptoms during your program  
***If you should become pregnant during this process please inform us immediately***
  - You have Ultrasound during your Menstrual Cycle but it is recommended to avoid the abdomen as you will not see the same results due to bloating\*\*\*
- Please inform us immediately if you have a change of health during your program that was not indicated on the intake