The Skin Renewal Studio

CONSENT TO TREATMENT

Body Contouring

Name: _____ DOB: _____

Address: _____

City: _____State:_____ Zip: _____

Phone: _____ Email Address: _____

Emergency Contact:

Name: _____ Phone: _____

Ultrasound Cavitation Treatments: *Check all that apply*

____ Abdomen ____ Upper Legs "Saddle Bags" ____ Lower Legs (Hamstring Area) ____ Inner Thigh

____ Arms (tricep side) ____ Back ____ Buttocks ____ Calf ____ Flanks "Love Handles" ____ Neck Fees

All costs are payable in-full prior to initial treatment and are non-refundable. Packages once purchased and treatment initiated are non-refundable.

Medical Background

Check any that apply

___ Are you pregnant or nursing? ___ Do you have hemophilia? ___ Are you epileptic?
___ Do you have thrombosis and/or thrombophlebitis? ___ Do you have any kind of tumor or cancer?
___ Do you have melanoma? ___ Do you have any cardiac or vascular disease or condition?
___ Have you undergone a transplant? ___ Do you have any acute inflammation?
___ Do you have a Neurological disorder? ___ Do you have a wound that has not healed?
___ Are you being treated with anticoagulants? ___ Do you have current or any history of internal bleeding?
___ Do you have any keloids? ___ Do you have a pacemaker or other electronic device?
___ Do you have any kind of heart trouble? ___ Do you have any plastic or bone cement or any large ___ Do you have any current infection? metal implant? Where?_____
___ Do you have any infectious disease or tuberculosis? ___ Have you had any abdomen operations? ___ Do you have advanced untreated diabetes? ___ Do you have any abnormally high or low blood pressure?
___ Do you have a communicable disease? ___ Do you have high levels of Triglycerides (hereditary)? ___ Do you have any type of heart, kidney, liver ___ Are you allergic to zinc or nickel? disease?

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

_____
_____
_____

Are you currently taking any medications? _____ Yes _____ No

If yes, please list: _____

Are you allergic to any foods or medication? List:

If yes, please list: _____

Please explain any other current medical conditions.

_____

Are you taking any vitamins/supplements?:

_____

Are you presently under a physician's care?

If yes, please explain: _____

Do you take recreational drugs?

_____

Please list your primary care physician's name and phone number:

_____

READ CAREFULLY – CONSENT TO TREATMENT 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 The Skin Renewal Studio does not guarantee any specific result. The Ultrasound Cavitation 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, hyper-triglyceridemia, hypercholesterolemia, pancreatitis, infection, scarring and/or allergic reaction to any products used, excessive thirst, dehydration, nausea. The Ultrasound Cavitation treatment includes, but is not limited to, the use of high-power low-frequency ultrasound cavitation which uses 40KHz 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. 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 or videos may be taken to document the treatment. These pictures or videos become The Skin Renewal Studio 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 The Skin Renewal Studio (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, The Skin Renewal Studio or other third parties, or in any way arising out of the above described treatment I have requested Ideal Health Center 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 The Skin Renewal Studio 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 Arizona law. I agree to indemnify, hold harmless and defend The Skin Renewal Studio (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 The Skin Renewal Studio perform. It is understood that any dispute arising as to malpractice of the Ultrasound Cavitation treatment shall be decided by a neutral arbitrator. Any arbitration proceeding will be governed by Arizona'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 Utah 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 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; 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 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 Name (Printed): _____

Client Signature: _____

Date Signed: _____

Accepted by Technician: _____

Date Signed: _____

READ CAREFULLY – CONSENT TO TREATMENT Financial Policy: We are honored to be of service to you. This is to inform you of our billing requirements and financial policy. Please be advised that payment for all services is due at the time services are rendered. We require full payment for the visit prior to being seen by our cavitation/or RF technician. We accept Venmo, Credit Card, Debit and Cash. In the event this account is referred to an agency for collections you agree to be responsible for all returned fees including any collections costs, collection's agency and/or attorney fees used for collection.

Client/Patient Name (Printed):_____

Client Signature: _____

Date Signed: _____

Accepted by Technician: _____

Date Signed: _____