Lipo-Light

Medical Disclaimer & Treatment Consent Form

Cavi-Lipo

Name: _____ DOB: _____ Age: ____ Ht: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Sex: Male:___ Female:___ Marital Status (Circle) **S M D W**

Home Phone: _____ Cell: _____ Seasonal Resident: ___Y ___N

Who Referred you here? _____ Magazine:___ Radio:___ Sign:___ Mail Ad:___

Main reason for this visit: _____

Are you being treated for any Medical Condition / Medical History? _____

_____

List any Previous Surgeries:_____

Medications & Allergies:_____

Please Check if you suffer from any of the Following: ___ Kidney/Liver Disease ___ Heart Disease
___Cancer ___Currently pregnant ___Medical Edema ___Auto Immune Disease ___Thyroid Problems
___Urinary Problems ___Diabetes ___Any Medal pins or plates ___Pacemaker **Do You Have**: ____Tattoos

Please read carefully and only sign if you are in full agreement with its contents

I, _____ confirm that I have understood the treatment being rendered and confirm that the above medical information is accurate. I am willing to proceed without confirmation from my primary physician or medical consultant.

You should note that if the Doctor or Therapist is unable to explain to you the contra-indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your primary physician.

It is your responsibility and not that of Rejuvenations Incorporated, or Staff to consult with your primary physician if necessary.

I hereby indemnify Rejuvenations Incorporated, staff and its affiliates against any adverse reaction sustained as a result of the treatment and confirm that all the information I have provided is correct.

Client: _____ Date: _____
Please Print

Client: (Signature): _____

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Treatment Consent Form -Cavi Lipo

I duly authorize the Doctors & Technicians of Rejuvenations Incorporated to perform the procedures for the purpose of body contouring, lymphatic drainage, improving the appearance of cellulite, and skin tightening. I am aware that the clinical results may vary depending on the individual factors, including, medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. I have been made aware that my diet and the amount of exercise I do with have a major effect on the results of my treatments. If I do not make the effort to address my diet and exercise, I am aware that the results achieved may not be retained.

I understand that the treatment by Rejuvenations Incorporated involves a course of treatments. The fee structure has been fully explained and I understand that I am required to pay for the course of treatments prior to any procedures taking place. I am fully aware that should I wish to cancel the course of treatments, that the value of the outstanding / remaining treatments is non-refundable.

Due to demand for treatments, we schedule all appointments following the initial consultation. Please be aware that all cancellations require a minimum of 24 hours notice. Failure to do so will result in that treatment being deducted from the course of treatments remaining without a refund. It is important to be aware that this may have a negative effect on your overall results. Any change to the initial treatment dates will be subject to availability. If you are more than 5 minutes late, we may not be able to accommodate your treatment appointment, as this may inconvenience other clients. Rejuvenations Incorporated reserves the right to deduct a treatment from your treatment course without refund.

I certify that I have been fully informed of the nature and purpose of the Cavi-Lipo procedure, expected outcomes, and possible complications. I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of a cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I understand that it is my personal responsibility to inform the Doctor or Therapist of any changes to my medical history during the course of treatment sessions and I confirm that should this occur, I shall advise the Doctor or Therapist of any changes.

Photo/Video Release:

I consent to the taking of Photographs and or Video /Video Testimonials and authorize their anonymous use for the purpose of medical audit, education, and promotion. [Delete if preferred]

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this Consent Form.

Client: _____ Date: _____
Please Print

Client: _____
Signature