***Sleek Reflections Body Sculpting, LLC.***

***READ CAREFULLY – INFORMED CONSENT TO TREATMENT***

Client #________________

# Ultrasound Cavitation Treatment Agreement

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

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

____ Abdomen
____ Inner Thigh
____ Buttocks
____ Upper Legs "Saddle Bags"
____ Arms (tricep side)
____ Calf
____ Lower Legs (Hamstring Area)
____ Back
____ Flanks "Love Handles"

**Fees.** All costs are payable in-full prior to initial treatment and are non-refundable. Payments must be completed for entire package price (1, 3, 6, 9 or 12 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:

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

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?___________________________________________________________________

Please list your family or primary treating physician name and phone number:

______________________________________________________________________________________________

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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 Sleek Reflections Body Sculpting, LLC. 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, hyper-cholesterolemia, 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 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.

**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 Sleek Reflections Body Sculpting, LLC. 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 Sleek Reflections Body Sculpting, LLC. (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, Sleek Reflections Body Sculpting, LLC. or other third parties, or in any way arising out of the above described treatment I have requested Sleek Reflections Body Sculpting, LLC. 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 Sleek Reflections Body Sculpting, LLC. 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 Florida law.

I agree to indemnify, hold harmless and defend Sleek Reflections Body Sculpting, LLC. (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 Sleek Reflections Body Sculpting, LLC. perform.

**Arbitration.** 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 Florida'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 Florida 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; 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 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__________________________________________(Printed) Date Signed____________________

Client Signature________________________________________________

Accepted by Technician_________________________________________ Date Signed____________________

**Sleek Reflections Body Sculpting, LLC.**

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Client #_______________

## Financial Policy:

Thank you for selecting Sleek Reflections Body Sculpting, LLC. for your health needs. 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 service provider. We accept Check, Credit Card, Debit and Cash. All forms of payment are immediately run through an electronic processing system and immediately deposited into electronic transfer system. In the event this account is referred to an agency for collections or if an electronic check is returned you agree to be responsible for all returned fees including any collections costs, collection's agency and/or attorneys fees used for collection.

## Informed Consent to Care:

The patient assumes all responsibility/liability if the patient does not report on any health forms any past medical history, illnesses, medicines, or allergies; or update the clinic of any changes during the course of treatment. I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

___________________________________ ____________

Patient's Signature Date

Client #_______________

**(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 want to maximize results.
- We recommend exercise to stimulate lymphatic flow. This includes low impact workouts, swimming, jogging and or cycling during this process. Even brisk 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 Ultrasonic Cavitation process.
- We recommend no more than one body area per lymphatic area and maximum of 30 min of ultrasound time for maximum results. Treatments can be done a minimum of 72 hours apart.
- **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 can have Ultrasonic Cavitation 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 form.