_____

CLIENT NAME

Target date for achieving your personal improvement goals: _____

Rate your level of commitment to achieving your personal improvement goals – (scale of 1 to 10 with 10 being the highest): _____

Are you willing to live a healthy lifestyle? Workout, eat healthy, moderate alcohol, etc.? _____

Areas of Desired Improvement:

ABDOMEN: ____	UPPER ARMS: _____	LOWER THIGHS: _____
INNER THIGH: ____	UPPER THIGHS: _____	UPPER BACK: _____
BUTTOCKS: _____	CALVES: _____	LOWER BACK: _____
JOWELS: _____	NECK: _____	BREAST: _____
EYES: _____	FOREHEAD: _____	

Please explain how you would like to improve all checked areas:

_____

_____

_____

_____ _____

Client Signature **Date**

PRESENT MEDICAL HISTORY

Do any of the following medical conditions apply to you? (Check all that apply)

- Pregnancy
- Epilepsy
- Cardiac or vascular disease/condition
- Acute inflammation
- Unhealed wounds
- History of internal bleeding
- Pacemaker or other electronic devices
- Plastic, bone cement or metal Implants
- Recent abdominal surgery
- Abnormal high or low blood pressure
- Do you get out of breath easily?
- Do you sometimes get out of breath when sitting still or sleeping?
- Has a doctor ever told you your cholesterol level was high?
- Communicable diseases
- Melanoma
- Thrombosis or thrombophlebitis
- Transplants
- Taking any anti-coagulants
- Keloids
- Heart trouble
- Current Infection
- Any infectious diseases or tuberculosis
- Diabetes
- Kidney or liver disease
- Metal tooth fillings

PLEASE LIST ANY MEDICATIONS: _____

_____

ARE YOU ALLERGIC TO ANY FOODS OR MEDICATIONS? _____

EXPLAIN ANY OTHER CURRENT MEDICAL CONDITIONS:

_____

_____

FOR FEMALES: ARE YOU PREGNANT OR NURSING? _____

ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE? IF SO, WHAT FOR?

_____

_____

TREATMENT AGREEMENT

NAME: _____

ADDRESS: _____

PHONE: _____ **EMAIL:** _____

THERMA-LIFT/ULTRASOUND CAVITATION/LIPO SCUPT LITE TREATMENTS:

CHECK ALL THAT APPLY:

ABDOMEN: ____	UPPER ARMS: _____	LOWER THIGHS: _____	INNER THIGH: _____
BUTTOCKS: ____	UPPER THIGHS: _____	UPPER BACK: _____	CALVES: _____
BRA ROLL: _____	BREAST: _____	LOWER BACK: _____	JOWELS: _____
FOREHEAD: _____	NECK: _____	BREAST: _____	EYES: ____

FEES: ALL COSTS ARE TO BE PAID IN FULL PRIOR TO INITIAL TREATMENT AND ARE NON-REFUNDABLE. COSTS DO NOT INCLUDE FUTURE VISITS, UNLESS OTHERWISE EXPRESSED. CLIENT MUST PAY FOR ANY SPECIAL OFFERS ON SECOND VISIT TO RECEIVE PACKAGE DISCOUNT. DISCOUNTED PACKAGES ARE NON-REFUNDABLE.

TREATMENT DISCLOSURE: THE 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 RENEW CONTOURING DOES NOT GUARANTEE ANY SPECIFIC RESULT.

AFTERCARE: CLIENTS ARE REQUIRED TO DRINK AT LEAST 1.5 LITERS OF WATER ON A DAILY BASIS WHEN UNDERGOING THIS PROCEDURE. ALSO, BE PREPARED TO COMPLETE A 30-45 MINUTE CARDIO WORKOUT. AFTERCARE INSTRUCTIONS HAVE TO BE FOLLOWED EXACTLY WHETHER GIVEN IN WRITING OR VERBALLY. FAILURE TO FOLLOW AFTERCARE INSTRUCTIONS MAY COMPROMISE THE FINAL RESULTS OF THE TREATMENT.

BEFORE, DURING AND AFTER PICTURE: BEFORE, DURING OR AFTER PICTURES MAY BE TAKEN TO DOCUMENT YOUR TREATMENT. THESE PICTURES BECOME RENEW CONTOURING'S SOLE PROPERTY AND ARE ONLY USED FOR ITS LEGITIMATE RECORD KEEPING.

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 HEARBY FULLY RELEASE AND FULLY DISCHARGE RENEW CONTOURING (INCLUDING ITS OFFICERS, MEMBERS, OWNERS, EMPLOYEES AND AGENTS) FROM ANY AND ALL DAMAGES, COSTS, EXPENSES, LIABILITIES, CAUSE OF ACTION, CLAIMS AND DEMANDS OF WHATEVER CHARACTER IN LAW OR EQUITY, WHETHER KNOWN OR UNKNOWN, DIRECT OR INDIRECT, ASSERTED OR UNASSERTED AND WHETHER OR NOT IN ACCOUNT OF MYSELF OR RENEW CONTOURING OR OTHER THIRD PARTIES WHOSE CLAIMS MAY ARISE OUT OF, OR RELATE TO, THE TREATMENT I HAVE REQUESTED RENEW CONTOURING 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 RENEW CONTOURING, 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 SHALL BE RESOLVED UNDER ALABAMA LAW.

RESULTS: I AGREE THAT RESULTS ARE SUBJECTIVE AND THAT MY LIFESTYLE CAN MITIGATE THESE RESULTS; THEREFORE, THE COST OF THE PROCEDURES ARE NON-REFUNDABLE.

IDEMNIFICATION: I AGREE TO INDEMNIFY, HOLD HARMLESS AND DEFEND RENEW CONTOURING (INCLUDING ITS OFFICERS, MEMBERS, OWNERS, EMPLOYEES AND AGENTS) AGAINST ALL THIRD PARTY CLAIMS, CAUSES OF ACTION, DAMAGES, JUDGEMENTS, COSTS OR EXPENSES, INCLUDING ATTORNEY'S FEES AND ANY OTHER LITIGATION COSTS, WHICH MAY IN ANY WAY ARISE FROM THE ABOVE DESCRIBED TREATMENT I HAVE REQUESTED RENEW CONTOURING TO PERFORM.

ARBITRATION: IT IS UNDERSTOOD THAT ANY DISPUTE ARISING AS TO MALPRACTICE OF THE THERMA-LIFT/ULTRASOUND CAVITATION/LIPO SCULPT LITE TREATMENT SHALL BE DECIDED BY A NEUTRAL ARBITRATOR. ANY ARBITRATION WILL BE GOVERNED BY ALABAMA ARBITRATION STATUTES. THE FEES FOR THE ARBITRATOR WILL BE SPLIT PRO-RATA AMONG THE PARTIES AND EACH PARTY WILL BE RESPONSIBLE FOR THEIR OWN ATTORNEY'S FEES AND COSTS. ANY ACTION TO COLLECT FEES FROM THE CLIENT/PATIENT FOR THE TREATMENTS PERFORMED MAY BE BROUGHT IN ANY COURT LOCATED IN ALABAMA AND PREVAILING PART. IN SUCH COLLECTION, ACTIONS SHALL BE ENTITLED TO RECOVER ANY REASONABLE ATTORNEY'S FEES AND COSTS. FILING OF ANY ACTION IN ANY COURT TO COLLECT ANY FEE FROM CLIENT/PATIENT SHALL NOT WAIVE THE RIGHT TO COMPLETE ARBITRATION OF ANY MALPRACTICE CLAIM.

BY SIGNING THIS AGREEMENT, I CONFIRM THAT I AM OVER THE AGE OF 18. I UNDERSTAND THAT THE 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 THE PROCEDURE'S RISKS AND HEREBY CONSENT TO THE INIDICATED PROCEDURES. THIS MEANS THAT I ACCEPT FULL RESPONSIBILITY FOR THESE AND/OR ANY OTHER COMPLICATIONS WHICH MAY ARISE OR RESULT DURING OR FOLLOWING THE PROCEDURE, WHICH IS TO BE PERFORMED AT MY REQUEST. ACCORDING TO THIS AGREEMENT, I HEREBY AGREE TO ARBITRATION OF ANY MALPRACTICE CLAIM. I FURTHER UNDERSTAND THAT THE COST OF THESE PROCEDURES ARE NON-REFUNDABLE AND THAT BY SIGNING THIS AGREEMENT, I VOLUNTARY SURRENDER CERTAIN LEGAL RIGHTS.

CLIENT: _____ **DATE:** _____

RENEW CONTOURING
(ACCEPTED BY TECHNICIAN): _____ **DATE:** _____

THERMA-LIFT CONSENT FORM

CLIENT: _____ DATE: _____

PURPOSE/PROCEDURE: THERMA-LIFT IS THE CONTROLLED RADIO-FREQUENCY HEALING OF DEEP SKIN WITH COOLING OF THE SURFACE SKIN. RADIO-FREQUENCY IS A RECENT AND NEW TECHNOLOGY WHICH HEATS THE UNDERLYING TISSUES IN THE SKIN, PROMOTING NEW COLLAGEN FORMATION.

RISKS: JUST AS THERE MAY BE BENEFITS TO THE PROCEDURE PROPOSED, I UNDERSTAND THAT ALL PROCEDURES INVOLVE RISKS TO SOME DEGREE.

DISCOMFORT: THIS TREATMENT USES HIGH HEAT. SOME PEOPLE MAY FEEL PAIN WITH THIS TREATMENT. THE DISCOMFORT IS USUALLY TEMPORARY, LASTING ONLY A FEW SECONDS.

REDDENING: TREATMENT MAY CAUSE A REDDENING OF THE AREA. THE REDDENING WILL USUALLY GO AWAY IN 1 TO 2 HOURS FOLLOWING TREATMENT. IN SOME INSTANCES, THE REDNESS CAN PERSIST FOR SEVERAL DAYS.

SWELLING: TREATMENT MAY CAUSE SWELLING, WHICH WILL USUALLY GO AWAY IN 3 TO 5 DAYS OR LESS.

BRUISING: TREATMENT MAY CAUSE BRUISING, BUT THIS IS EXTREMELY UNCOMMON.

ALTERED SENSATION: THERE MAY BE ALTERED SENSATION, OR PERMANENT OR TRANSIENT NERVE DAMAMGE AT THE TREATMENT SITE. HOWEVER, THIS IS EXTREMEMLY UNLIKELY BECAUSE THE SYSTEM HAS BEEN DESIGNED TO DELIVER A CONTROLLED APPLICATION OF ENERGY TO THE TISSUE.

PIGMENT CHANGES: THE TREATED AREA MAY HEAL WITH INCREASED OR DECREASED PIGMENTATION. THIS OCCURS MOST OFTEN WITH DARKER PIGMENTED SKIN AND AFTER EXPOSURE OF THE AREAS TO THE SUN. YOU MAY HAVE EXPERIENCED THIS TYPE OF REACTION BEFORE WITH MINOR CUTS OR ABRASIONS. THE TREATED AREA MUST BE PROTECTED FROM EXPOSURE TO THE SUN (WE RECOMMEND COVERING THE AREA WITH SUNSCREEN FOR 2-3 WEEKS FOLLOWING TREATMENT).

RESTRICTIONS: I UNDERSTAND THAT IF I'VE HAD DERMA FILLER WITHIN THE PAST 2 MONTHS OR NEUROTOXIN (BOTOX, DYSPORT, JUVEDERM) WITHIN THE PAST 2 WEEKS, IT IS POSSIBLE THAT THE HEAT FROM THE THERMA-LIFT CAN BREAK DOWN AND DIMINISH THE EFFECTIVENESS OF THE DERMA FILLER OR NEUROTOXIN. I ALSO UNDERSTAND THAT FOLLOWING MY THERMA-LIFT TREATMENT, IT IS BEST TO AVOID DERMA FILLER FOR 2 MONTHS AND NEUROTOXIN FOR 2 WEEKS.

BENEFITS: TIGHTENS AND LIFTS SAGGING SKIN. OVER TIME, NEW COLLAGEN IS PRODUCED TO FURTHER TIGHTEN THE SKIN, RESULTING IN HEALTHIER, SMOOTHER SKIN AND A MORE YOUTHFUL APPEARANCE.

CONSENT: YOU HAVE READ THIS FORM AND UNDERSTAND IT. YOU REQUEST THE PERFORMANCE OF THE PROCEDURE DESCRIBED ABOVE. YOU HAVE BEEN GIVEN A COPY OF THIS CONSENT FORM UPON REQUEST. YOUR CONSENT AND AUTHORIZATION FOR THIS PROCEDURE IS STRICTLY VOLUNTARY. BY SIGNING THIS INFORMED CONSENT FORM, YOU HEREBY GRANT AUTHORITY TO PERFORM THERMA-LIFT.

THE NATURE AND PURPOSE OF THIS PROCEDURE, WITH POSSIBLE COMPLICATIONS, HAVE BEEN FULLY EXPLAINED TO YOUR SATISFICATION. NO GUARANTEE HAS BEEN GIVEN BY ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED BY THIS TREATMENT.

I AGREE TO HAVE PHOTOGRAPHS TAKEN FOR DOCUMENTATION, AS WELL AS INTERNAL OFFICE USE.

I HAVE READ THIS CONSENT AND CERTIFY THAT I UNDERSTAND ITS CONTENTS IN FULL. I HAVE HAD ENOUGH TIME TO CONSIDER THE INFORMATION AND FEEL THAT I AM SUFFICIENTLY ADVISED TO CONSENT TO THIS PROCEDURE. I HEREBY GIVE MY CONSENT TO THIS PROCEDURE AND HAVE BEEN ASKED TO SIGN THIS FORM AFTER MY DISCUSSION WITH RENEW CONTOURING.

_____ _____

CLIENT SIGNATURE **DATE**

LIPO SCULPT LITE/ULTRASONIC CAVITATION CONSENT FORM

CLIENT: _____ DATE: _____

PURPOSE/PROCEDURE:
LIPO SCULPT LITE: HIGH INTENSITY LIGHT TECHNOLOGY REDUCES POCKETS OF UNWANTED FAT PAINLESSLY WHEN DIET AND EXERCISE FAIL. HIGH INTENSITY LIGHT BREAKS DOWN EXTREMELY STUBBORN FAT CELLS.

ULTRASONIC CAVITATION: THE TREATMENT INCLUDES, BUT IS NOT LIMITED TO, THE USE OF HIGH POWER LOW FREQUENCY ULTRASOUND. CAVITATION USES 25 KHZ TO 40 KHZ 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 FORCES THEM TO IMPLODE, THUS BREAKING DOWN THE ADIPOCYTES' CELL MEMBRANE.

RISKS: JUST AS THERE MAY BE BENEFITS TO THE PROCEDURES PROPOSED, I UNDERSTAND THAT ALL PROCEDURES INVOLVE RISKS TO SOME DEGREE. THE ULTRASOUND CAVITATION TREATMENT CARRIES WITH IT POSSIBLE HEALTH COMPLICATIONS AND CONSEQUENCES, WHICH INCLUDE, BUT ARE NOT LIMITED TO, THE RISKS OF KIDNEY FAILURE, LIVER FAILURE, PACEMAKER FAILURE, BIRTH DEFECTS, MISCARRIAGE, HYPERCHOLESTEROLEMIA, PANCREATITIS, INFECTION, SCARRING, ALLERGIC REACTIONS TO ANY PRODUCTS USED, EXCESSIVE THIRST, DEHYDRATION AND NAUSEA.

DISCOMFORT: PRESSURE IS APPLIED, ACCOMPANIED WITH A LIGHT BUZZING NOISE IN THE EAR. PATIENT MAY EXPERIENCE A TINGLING/HEATED SENSATION.

REDDENING: TREATMENT MAY CAUSE A REDDENING OF THE AREA. THE REDDENING WILL USUALLY GO AWAY IN 1 TO 2 HOURS FOLLOWING TREATMENT. IN SOME INSTANCES, THE REDNESS CAN PERSIST FOR SEVERAL DAYS.

SWELLING: TREATMENT MAY CAUSE SWELLING, WHICH WILL USUALLY GO AWAY IN 3 TO 5 DAYS OR LESS.

BRUISING: TREATMENT MAY CAUSE BRUISING, BUT THIS IS EXTREMELY UNCOMMON.

RESTRICTIONS: YOU SHOULD AVOID ALCOHOL AND CAFFEINE THE DAY OF THE PROCEDURE AND 24 HOURS FOLLOWING TREATMENT. MAKE SURE TO ADHERE TO A HEALTHY DIET THAT WILL NOT COUNTERACT THE PURPOSE OF THE TREATMENT.

CONSENT: YOU HAVE READ THIS FORM AND UNDERSTAND IT. YOU REQUEST THE PERFORMANCE OF THE PROCEDURE DESCRIBED ABOVE. YOU HAVE BEEN GIVEN A COPY OF THIS CONSENT FORM UPON REQUEST. YOUR CONSENT AND AUTHORIZATION FOR THIS PROCEDURE IS STRICTLY VOLUNTARY. BY SIGNING THIS INFORMED CONSENT FORM, YOU HEREBY GRANT AUTHORITY TO PERFORM THERMA-LIFT.

THE NATURE AND PURPOSE OF THIS PROCEDURE, WITH POSSIBLE COMPLICATIONS, HAVE BEEN FULLY EXPLAINED TO YOUR SATISFICATION. NO GUARANTEE HAS BEEN GIVEN BY ANYONE, AS THE RESULTS THAT MAY BE OBTAINED BY THIS TREATMENT MAY VARY.

I AGREE TO HAVE PHOTOGRAPHS TAKEN FOR DOCUMENTATION, AS WELL AS INTERNAL OFFICE USE.

I HAVE READ THIS CONSENT AND CERTIFY THAT I UNDERSTAND ITS CONTENTS IN FULL. I HAVE HAD ENOUGH TIME TO CONSIDER THE INFORMATION AND FEEL THAT I AM SUFFICIENTLY ADVISED TO CONSENT TO THIS PROCEDURE. I HEREBY GIVE MY CONSENT TO THIS PROCEDURE AND HAVE BEEN ASKED TO SIGN THIS FORM AFTER MY DISCUSSION WITH RENEW CONTOURING.

_____ _____

CLIENT SIGNATURE **DATE**

APPOINTMENT CANCELLATIONS

RENEW CONTOURING AND OUR STAFF PRIDE OURSELVES ON ENSURING LOW COST TREATMENTS AND THAT ALL OF OUR PATIENTS ARE SEEN ON TIME, WITHOUT ANY UNNECESSARY WAIT TIMES TYPICALLY EXPERIENCED WITH OTHER MEDICAL FACULTIES.

TO ACCOMPLISH THIS, WE RELY UPON OUR PATIENT'S COMMITMENT TO KEEPING THE APPOINTMENTS THEY HAVE SCHEDULED FOR THEIR CONVENIENCE.

TO ENSURE THAT YOU ARE SEEN PROMPTLY AT YOUR DESIRED TIME, WE STRICTLY AVOID ANY OVERBOOKING.

YOUR TECHNOLOGIST IS ASSIGNED TO YOU AT THE APPOINTMENT TIME YOU HAVE REQUESTED.

RENEW CONTOURING'S UNIQUELY AFFORDABLE PRICING IS CAREFULLY CALCULATED UPON OUR PATIENTS' ABILITY TO KEEP THE APPOINTMENTS THEY HAVE COMMITTED TO.

AN AUTOMATED TEXT MESSAGE AND EMAIL WILL BE SENT TO REMIND YOU OF YOUR APPOINTMENT DAYS IN ADVANCE.

THEREFORE, PLEASE NOTIFY US 24 HOURS IN ADVANCE IF YOU CANNOT KEEP YOUR APPOINTMENT SO WE HAVE THE OPPORTUNITY TO SCHEDULE ANOTHER PATIENT WITHIN YOUR APPOINTMENT TIME.

ANY APPOINTMENTS MISSED OR CANCELLED THE DAY OF PROCEDURE WILL AUTOMATICALLY ASSESS A $50.00 FEE TO PARTIALLY COVER THE COST OF THE TECHNICIAN ASSIGNED TO YOUR APPOINTMENT. AN INVOICE WILL BE SENT TO YOUR EMAIL WITH A PENALTY FEE. PLEASE BE ADVISED YOU CANNOT BE SEEN UNTIL THAT FEE IS PAID IN FULL.

_____ _____

CLIENT SIGNATURE **DATE**