INFORMED CONSENT FOR BODY SCULPTING/FACIAL TREATMENTS

I, _____ give my consent for body sculpting and/or facial treatments to be performed by *Enhanced Body Bar, Body Sculpting and Aesthetics.*

Please read and initial each of the following statements below:

_____ I certify that I am over the age of 18.

_____ I have voluntarily elected to receive body sculpting/facial treatments after the nature and purpose of this treatment has been explained to me.

_____ I understand that body sculpting can be used to reduce fat deposits, but is NOT intended to be a weight loss solution.

_____ I understand that the following conditions preclude me from having this treatment and verify that none of the following conditions apply to me at this time:

- Cardiac condition(s)
- Cancer
- Infected, inflamed or swollen skin
- Metallic implant (pacemaker)
- Pregnant and/or lactating

_____ I recognize there are no guaranteed results.

_____ I understand and acknowledge that there are risks involved with the treatment I will be receiving including, but not limited to:

- Redness
- Swelling
- Irritation
- Skin reaction
- Increased heart rate

_____ I have been informed of possible benefits, risks and complications. I have had the opportunity to ask questions regarding these risks and other possible complications.

_____ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all side effects, injuries, losses, or damages which might occur to me while I am undergoing the procedure(s). I do not hold the technician or *Enhanced Beauty Bar, Body Sculpting and Aesthetics* responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

NAME PRINTED	CLIENT SIGNATURE	DATE
_____	_____	_____

NEW CLIENT INFORMATION FORM

Full Name: _____ Date: _____

Address: _____ DOB: _____ Gender at birth M____ F_____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____ 2ndary Phone: (_____)_____

Email: _____ Occupation: _____

How did you hear about us? Please name person referred by, if applies:

Personal referral _____ Social Media _____ Web search _____ Website _____ other _____

Height: _____ Weight: _____ Ethnicity: _____

What area(s) would you like us to focus on? _____

MEDICAL HISTORY

Do you have any chronic medical conditions which we should know about? YES _____ NO_____

If so, please list: _____

Do you have any allergies to latex, medications, herbal or natural supplements? YES _____ NO _____

If so, please list: _____

Do you have/had any changes in your medical condition recently? YES _____ NO _____

If so, please explain: _____

Do you have hearing aids, a pacemaker, hormone pellets or metal/medical devices implanted? YES _____ NO _____

If so, please indicate what and where on your body: _____

Do you have Diabetes? Type 1 or 2? YES _____ NO _____

List all current medications including vitamins: _____ YES _____ NO _____

Do you have/had cancer in the last 12 months? YES _____ NO _____

If so, are you currently on chemotherapy? YES _____ NO _____

Do you have a thyroid problem? YES _____ NO _____

Do you have high blood pressure or any cardiovascular conditions? YES _____ NO _____

Are you currently pregnant or nursing? YES _____ NO _____

Put an X next to all medical conditions which apply to you:

Epilepsy	Neck/back problems
Gallbladder removed	History of gallstones
History of liver problems	Colon problems
Protruding/distended	Implants of any kind
belly Infections	Tumors
Skin Disease Thrombosis/	Autoimmune disease
phlebitis	Abnormal skin sensitivities/sensations

Other: _____

Are you currently dieting? YES _____ NO _____

If so, please explain: _____

Indicate typical daily food/fluid intake. How much/how often? :

Water: _____ Coffee: _____ Soda/Carbonated Bev: _____ Alcohol: _____

Fast foods: _____ Tobacco use: _____ Recreational Drugs: _____

Current stress Level: Low _____ Moderate _____ High _____

I, (print name) _____, consent to allow *Enhanced Beauty Bar, Body Sculpting and Aesthetics* staff members to consult with and evaluate me in order to determine if I am a good candidate for the non-surgical/non-invasive body contouring program. I understand and consent to body measurements and photography/video being taken and archived.

I agree that these forms have been completed truthfully and to the best of my knowledge and abilities.

CLIENT SIGNATURE _____ Date_____

CONSENT FORM

Body sculpting increases flow of both the lymphatic and circulatory systems, helping with cleansing of the tissues. The main purpose of body sculpting treatment is inch loss, diminishing of cellulite and tightening of the skin.

BENEFITS

Lose 1-3 inches per treatment with state of the art equipment. Benefits are often immediate, but may be delayed in some people.

FOR BEST RESULTS

A series of 9-12 body sculpting treatments are recommended per each area, but some individuals may require more treatments to achieve maximum and desired results. There should be at least 3 days between each treatment on the same area. This is not a weight loss treatment, but an inch loss. The inches will only return if the client goes back to their old habits. Eating the right types of food, proper exercise and drinking at least 8 glasses of water per day are always recommended. It is recommended that you exercise within 4-6 hours of treatment and avoid sugar and alcohol for 24 hours after each treatment.

PRECAUTIONS

Body sculpting treatments are NOT recommended if you are pregnant, breast feeding, have a lymphatic disorder, acute illness, metal implants, pacemakers, or are currently being treated for active cancer.

WAIVER

I understand that I am using the VIBRATION machine provided at my own risk. Should I sustain any injury while using this equipment, I agree to not hold *Enhanced Beauty Bar, Body Sculpting and Aesthetics*, the service provider responsible for any damages.

ACKNOWLEDGEMENT

By my signature below, I certify that I have read and understand the contents of this consent form. I further agree to provide 24 hour notice of cancellation or change in appointment time, or I will forfeit a treatment off my package since treatment is by appointment only. I understand and acknowledge that payments for the above services are NON-REFUNDABLE. I understand that there are no refunds if I am responding to treatment and decide to stop treatment. Should I decide to add an ultrasound treatment and/or radio frequency treatment, that treatment will be considered an additional and separate treatment. This extra treatment can be paid for separately or deducted from the number of treatments in my selected PACKAGE. Should *Enhanced Beauty Bar, Body Sculpting and Aesthetics*, the service provider, wish to use any photos of my progress other than for my personal file; I will sign a separate photo release form.

CLIENT SIGNATURE _____ DATE_____

CANCELLATION/TARDINESS POLICY

CANCELLATION

If there is a need to cancel for any reason, a 24 hour notice is required. Please understand that when you do not cancel or show up for an appointment, it is a cost to us. If you cannot provide us with a 24 hour notice, we *may* impose the following fees:

"No Show" for session:

*loss of that treatment in your treatment package

Same day cancellation:

*$ 50.00 charge before your next scheduled treatment

TARDINESS

You are expected to start your treatment(s) at the agreed upon scheduled time. A late start does not entitle you to a treatment(s) longer than the scheduled appointment. For example: If you are 20 minutes late for a 60-minute treatment, your treatment will be reduced to 40 minutes and you will not receive credit for the remaining 20 minutes.

I, (print name) _____, have read and understand the cancellation policy of *Enhanced Beauty Bar, Body Sculpting and Aesthetics*, the service provider, and agree to abide by the above conditions.

CLIENT SIGNATURE _____DATE _____

TERMS OF ACCEPTANCE/INFORMED CONSENT

Please read carefully and understand the contents of this form. Feel free to ask *Enhanced Beauty Bar, Body Sculpting and Aesthetics* staff about any portion of these documents if you do not understand.

When a client seeks body contouring services and when the service provider accepts a client, it is essential that both are seeking and working for the same goals. We expect our client to take full responsibility for their decisions to participate in any of the services/treatments offered by this office. We have only one goal: TO OPTIMIZE YOUR BODYS ABILITY TO FUNCTION NORMALLY AND OPTIMIZE YOUR FAT BURNING POTENTIAL. By reducing bio-stress levels, we allow the bodys inborn self-correcting mechanism to work at maximum efficiency to restore, maintain and promote wellness.

We do not identify, diagnose, or treat ANY medical condition(s) or disease(s). We do not offer treatment for any condition(s) or disease(s). We promise no cure from any condition(s) or disease(s). Instead, we facilitate your bodys own self-correcting mechanism.

It is essential that you speak to your doctor prior to making any decisions about altering any medical regimen you are currently following, changing your diet, taking supplements, or going on an exercise and/or weight loss program. Getting your doctor's approval prior to starting any service/program at our office is critical and solely your responsibility. Should any health condition arise while you are a client, we recommend that you immediately see the appropriate health care provider.

Any opinions that are rendered by the *Enhanced Beauty Bar, Body Sculpting and Aesthetics* staff and/or head personnel should NEVER/be construed as medical advice, but merely as opinions. If you would like medical advice, please seek advice from a medical professional or your primary care doctor. We will NOT handle any medical condition.

With your signature below, you understand and voluntarily accept these risks and agree that neither *Enhanced Beauty Bar, Body Sculpting and Aesthetics*, the service provider, its staff, nor any of its partners will be liable for any injury to you, including, but not limited to, personal bodily injury, mental injury, death, economic loss of any damage to you, your spouse, or relatives resulting from any act of *Enhanced Beauty Bar, Body Sculpting and Aesthetics*, the service provider, and its staff or anyone else using the facilities. You also acknowledge the inherent risks of the positions, movement, dietary/nutritional programs offered to and done to you at the service provider, with respect to your current or past conditions(s). If there is any dispute between you and the service provider and/or any of its staff, both parties agree to submit it to binding arbitration. We both agree to have a neutral arbitrator preside over any such dispute, not a judge or jury.

I, (print name) _____, understand and accept the conditions as laid out in the "TERMS OF ACCEPTANCE" above.

CLIENT SIGNATURE_____ DATE_____

Office acceptance by: _____

SERVICE AGREEMENT

The following provisions apply to the services to be performed for (printed name) _____.

1. SERVICES TO BE PROVIDED
   Enhanced Beauty Bar, Body Sculpting and Aesthetics, provides ultrasound cavitation, radio frequency treatments, laser lipo, cellulite treatments, facial treatments, vacuum Brazilian butt lift and sauna blanket body wraps.

2. PAYMENT
   Payment in full is to be made prior to the start of any treatment.

3. CLIENT COOPERATION
   This agreement contemplates full client cooperation in the course of services agreed upon. This cooperation includes client's agreement to remain active in the recommended program for the contouring visits. The client recognizes that compliance with recommended services and service schedule is important and the client agrees to follow the service plan and the course of treatment agreed upon. The client understands that lack of cooperation, failure to keep appointments and engaging activities identified by the office as potentially counterproductive to the body may necessitate additional treatments to those otherwise provided for this agreement. Our office policy requires 24 hour advance notice for appointment cancellation. Failure to do so may result in deduction of pre-paid visits.

4. TERMINATION
   Subject to the provisions of paragraphs 5 and 6 of this agreement, the client may discontinue care and terminate this agreement at any time by written notice to that effect delivered in person or by e-mail to the office. Such "notice of termination" shall discharge the office from all further obligations and /or duty to render services to the client. The office reserves the right to terminate this agreement in its sole discretion not withstanding any other terms or provisions of this agreement. Without discrimination in any way, shape or form, this office reserves the right to refuse service to any customer.

5. NO REFUNDS IN THE EVENT CLIENT TERMINATES AGREEMENT
   To encourage commitment and follow through, the service provider offers NO refunds. No refunds will be made on any body contour and facial treatments. There will be no exceptions. The prepaid program cannot be altered, shared or transferred, nor can it be combined with any other program.

6. NO GUARANTEE OF RESULTS
   Client recognizes that neither office personnel nor this agreement provides a guarantee of results. The office makes no guarantee of the extent of longevity of improvement to be expected. This agreement deals solely with the services to be rendered and the fees to be paid for the care as provided. The client's payment obligation is not contingent upon the outcome of services. Client's results can be hindered and/or suppressed by the consumption of the following, but are not limited to, alcohol, processed foods including , but not limited to, sugar=-based foods and drinks, etc. It is recommended to consult a professional for dietary modification clearance if you have any questions or concerns.

7. TIME LIMITATION FOR SERVICES

   Client understands that unused visits will expire if not used within 120 days from the date client starts the treatment unless the office has been provided with advance notice in writing of leave of absence or other cause of delay. After 24 weeks, all outstanding services/visits will be void.

8. RELEASE OF LIABILITY

   Client agrees to indemnify, hold harmless and release the service provider, its agents, employees, officers, directors, representatives, assigns, members, affiliated organizations and insurers, and others acting on the company's behalf, of all claims, demands, causes of action, and legal liability, whether the same be known of unknown, anticipated or unanticipated, and further agrees that except in the events of the company's gross negligence or willful and wanton misconduct, no claims, demands, legal actions and causes of action, shall be against the company for any economic and non-economic losses of any kind.

9. YOUR RESPONSIBILITIES
   1. Keep your appointments. We require 24 hour advance notice to reschedule/cancel an appointment.
   2. Follow your program as closely as possible. Report any deviations to the office staff so that we can help you get back on track.
   3. If you have any challenges whatsoever, please share them with us immediately. Remember, it is in both our interests for you to succeed in achieving your goals.
   4. If you have any medical conditions, please share this program with your physician immediately. The service provider is not a medical facility and does not make medical decisions.

10. GOVERNING LAW

    This agreement shall be governed, construed and interpreted by, through and under the Laws of the State of California.

11. COMPLETE AGREEMENT

    The agreement constitutes the complete agreement and understanding between client and office and will not be changed or modified in any way unless agreed by both parties in writing.

THE CLIENT HAS FULLY READ THIS AGREEMENT AND ANY SUPPLEMENT HERETO, AND UNDERSTANDS AND AGREES TO ABIDE BY ALL OF THE TERMS HEROF.

Printed NAME _____

CLIENT SIGNATURE _____ DATE _____

Office acceptance BY_____ DATE _____

PHOTO/VIDEO/AUDIO/MEDIA RELEASE

Participant agrees that any pictures, audio or visual recording taken of him/her in connection with the treatments can be used for publication, promotion, articles, shows and advertisement without additional consent and without compensation at this time or any other time.

I have read and understand this release and agreement and agree to it provisions. I am not under the influence of any drugs, alcohol, or other intoxicants. I am not suffering from any illness or incapacity. I am over 18 years of age.

Printed NAME _____

CLIENT SIGNATURE_____ DATE _____