The FIRM U

A CLINICAL FITNESS STUDIO

STRAWBERRY LASER LIPO INCH LOSS CONSENT FORM

Name		
Street Address		
City, State, Zip		
Cell Phone		
Email Address		
Age	☐ **Male**	☐ **Female**

I duly authorize the technicians of The Firm U to perform the Laser Lipo Inch Loss procedure for spot fat reduction and skin tightening. I am aware that clinical results may vary depending on 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 will have a major effect on the results of my treatments. **If I do not make an effort to address my diet and exercise, I am aware that the results will not be retained.**

I understand that treatment with the Laser Lipo machine involves a course of 8 treatments. The fee structure has been fully explained and I understand that I am required to pay for the treatment prior to any procedures taking place. I am fully aware that should I wish to cancel the course the outstanding treatment value is non-refundable. The course cost is $__________________ and is for ________ treatment sessions (________client's initials).

My treatment days are (schedule is subject to change):

Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐

Due to the demand for treatments, all 8 appointments are scheduled following the initial consultation. I have been made aware that all cancellations require a minimum of 24 hours' notice. Failure to do so will result in that treatment being forfeited. I am aware that this may have a negative effect on the overall results. Any changes to the initial treatment dates will be subject to availability.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications. I understand that no guarantee can be given as to the 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 clinician of any changes to my medical history during the course of Laser Lipo treatment sessions and I confirm that should this occur, I shall advise the clinician of any changes.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit. education, marketing and promotion.

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.

I have read this agreement thoroughly and understand the terms. My participation in the selected program and my execution of this agreement are both purely voluntary and I elect to do so despite the risks.

____________________________ ____________________________ ____________________

Printed Name Signature Date

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STRAWBERRY LASER LIPO INCH LOSS MEDICAL QUESTIONNAIRE

Name

Please list any / all medications you are currently taking:

____

____

Have you ever experienced any of the following conditions?

CONDITION	YES / NO	NOTES
Any kidney problems?	Yes ☐ No ☐	
Any liver problems?	Yes ☐ No ☐	
Are you currently pregnant?	Yes ☐ No ☐	
Auto immune disease	Yes ☐ No ☐	
Cancer	Yes ☐ No ☐	
Cardiovascular	Yes ☐ No ☐	
Circulation	Yes ☐ No ☐	
Diabetes	Yes ☐ No ☐	
Digestive	Yes ☐ No ☐	
Epilepsy	Yes ☐ No ☐	
Gynecological	Yes ☐ No ☐	
Immune System	Yes ☐ No ☐	
Metal pins or plates	Yes ☐ No ☐	
Muscular/skeletal	Yes ☐ No ☐	
Thyroid	Yes ☐ No ☐	
LIFESTYLE QUESTIONS		
Do you have regular periods?	Yes ☐ No ☐	
Do you work at a computer?	Yes ☐ No ☐	
Do you eat regular meals?	Yes ☐ No ☐	
Do you eat in a hurry?	Yes ☐ No ☐	
Do you exercise?	Yes ☐ No ☐	
Do you suffer allergies?	Yes ☐ No ☐	
How would you mark your current stress level?		
Date of your last visit to the doctor		

Additional conditions not listed (please list below):

____

____

Printed Name _______________ Signature _______________ Date _______________