Lipo-Light
The natural way to inch loss

MEDICAL AND DISCLAIMER FORM

Name: ..... **Age:** ..... **M / F**

Address: .....

..... **Zip code:** .....

Telephone: ..... **Mobile:** .....

Email: ....

How did you hear about us?

Magazine ☐ Direct Mail ☐ TV ☐ Signage ☐
Radio ☐ Word of Mouth ☐ Other ☐

Are you currently or have you suffered from any of the following:

	Yes	No
Kidney/liver disease	☐	☐
Heart disease	☐	☐
Cancer	☐	☐
Currently pregnant	☐	☐
Medical edema	☐	☐
Auto immune disease	☐	☐
Any metal pins or plates	☐	☐
Thyroid problems	☐	☐
Urinary infection	☐	☐
Diabetes	☐	☐

Any condition already being treated by a medical practitioner:

……

……

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

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

You should note that if the 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 PWLC staff to consult your primary physician if necessary.

I hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment and confirm that all the information I have given is correct.

Signed…… Date……/……/……..

Lipo-Light
The natural way to inch loss

TREATMENT CONSENT FORM

Title: [Mr/Mrs/Miss] .....

Client Name: .....

Address: .....

.....

Zip Code: .....

I duly authorise the technicians of **Lipo-Light** to perform the procedure for the purpose of body contouring, lymphatic drainage, improving the appearance of cellulite 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 achieved may not be retained.

I understand that treatment by **Lipo-Light** involves a course of treatments. The fee structure has been fully explained and I understand that I am required to pay for a course of treatments prior to any procedures taking place. I am fully aware that should I wish to cancel the course, the value of the outstanding treatment 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 your course without a refund. It is important to be aware that this may have a negative effect on your overall results. Any changes 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. PWLC reserves the right to deduct a treatment from your treatment course without a refund.

I certify that I have been fully informed of the nature and purpose of the **Lipo-Light** procedure, expected outcomes and possible complications, and 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 am aware that the **Lipo Light** may cause slight hypo/hyper-pigmentation of the skin and treatment is taken at my own risk (tattoo areas should be avoided).

I understand that it is my personal responsibility to inform the 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 therapist of any changes.
I consent to the taking of photographs and authorise their anonymous use for the purposes 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 signature ..... Date ...../...../.....

Witness signature ..... Date ...../...../.....