

Personal Information:

Date: _____

First name: _____ Last name: _____

Address: _____

E-Mail: _____

Mobile number: _____

Date of Birth: _____ Age: _____ Gender: _____

How did you hear about us? _____

Which treatment and what areas (e.g. legs) are you interested in having?

Laser Lipo: _____

Ultrasonic Cavitation: _____

Fat Freeze: _____

Bipolar / Tripolar RF/ Vacuum: _____

What are your goals and expectations of the treatment?

Have you used any of the following in the past 30 days?

___ None ___ Tanning beds ___ Self-tanning cream ___ Sun Tanning

Check any of the following that applies too you.

Heart disease___ Acne___ Blood thinners___ Cancer___

Polycystic Ovarian syndrome___ Herpes (or cold sores) ___ Hirsutism___

Lupus___ Liver / Kidney disease___ Clotting Disorders___ Diabetes___

Epilepsy___ Aids___ Psoriasis___ Pregnant___ Breast Feeding___

Specify any medical condition not listed _____

List any medications that you are currently taking _____

If you have any implants, list the area _____

Do you have any skin sensitivities or allergies? _____

Have you had any major surgery in the last 3 months? _____

Informed Consent

Laser Lipo/ Cavitation / Fat freeze

The AW3® fat loss treatment is a method of removing fat/ cellulite. Everyday lifestyle, diet and lack of exercise can influence production of fat and the body appearance. Treatments using the AW3® system will not cure any medical conditions or alter the natural production of fat to your body.

The purpose of the treatment is to achieve improvements in the appearance of the body or skin tightening by removing unwanted fat and reducing the area in size, the results do vary from person to person. As part of the program, regular exercise and good diet will aid the treatment to work more effectively.

Radio Frequency Skin Tightening

AW3® radio frequency technologies used to tighten and induce collagen production for skin tightening, wrinkle reduction, acne scarring and to minimize pores.

The radio frequency produces two or three currents depending on whether it is bipolar/ tripolar/ multipolar which alternate high and low frequency currents no less than a thousand times per second. This heats the deeper skin tissues to promote blood circulation to tighten the skin. At the same time, the cooling measures are taken on the skin surface by applying cooling ultrasound gel.

The purpose of the treatment is to achieve improvements in the appearance of the skin. The dermal layer of the skin becomes thickened, with the new collagen production and the wrinkles are pushed out, so the skin becomes firmer and the contours are lifted.

Accepting Terms and Consent*

I hereby authorize _____ to treat me using the AW3® system.

I agree to follow the post treatment recommendations advised by the operator/company in order to ensure the best possible results. I understand that after treatment within 24 hours I will need to do 10 minutes of exercise to help fat leave the body through the lymphatic system. I will also drink 1.5 to 2 liters of water to help flush the fat to get maximum results. I Agree to co-operate with the recommendations of the company or the personnel while I am under their care, realizing that any lack of co-operation could result in less than optimum results.

I understand that the removal of fat or skin tightening is a very effective cosmetic procedure. Although we can achieve great results, absolute success is a variable and cannot be guaranteed. Multiple treatments may be necessary to achieve the best results.

I have been informed about alternative treatment possibilities and I understand that other forms of treatment or no treatment at all, are choices that I have.

I understand that there are certain risks associated with light treatment and they include but are not limited to the following:

Although uncommon the above treatments may cause bruises, swelling and temporary redness to the surface of the skin.

I agree to inform the above company/operator immediately if any adverse effects occur. I agree to photographic documentation of the treated area prior to treatment.

I certify that I have read the entire informed consent and I agree to all its provisions. I certify that I have had the opportunity to ask questions and these questions have been answered to my satisfaction. I fully understand the treatment conditions and procedure.

I agree to pay for the above-mentioned services and understand that there will be **no refunds** for any performed services. This consent form and cost covers above selected treatments only. Additional treatments can be added to this consent form and will be charged for as per clinic price list, including single session.

I have been made aware of the risks and I accept these terms and conditions as part of my treatment. We, the company or the operator accept no liability for any of the above side effects. By accepting this, I agree to the terms and conditions and in the event of any of the above. I or any of my representative will not pursue the above person / company in any means of compensation.

Customer Full Name: _____

Signature: _____

Date: _____