



## ULTRASONIC CAVITATION PATIENT CONSENT

Ultrasonic Cavitation are technologies for breakdown of the fat deposits. These procedures do not involve invasive surgery - there is no need for anesthesia, hospital stay and no down time. They provide a non-invasive method to break down stubborn fat deposits that never seem to disappear no matter what your diet is or how hard you exercise. The most problematic body areas are abdomen, flanks (love handles), inner thighs, buttocks, inner knees, under chin and upper arm.

Appointments are usually scheduled every 2-3 times a week. In order to ensure maximum results, it is necessary to follow the recommended treatment schedule. The total number of treatments will vary between individuals. **On occasion, there are patients that do not respond to treatments.** I understand the nature, goals, limitations and possible complications of this procedure and have discussed alternative forms of treatment. I have had the opportunity to ask questions about the procedure, as well as any limitations, complications and/or side effects.

I have read, agree to, and understand the following:

- The goal of any treatment, as in any cosmetic procedure, is improvement, not perfection, and results may not be perfect due to any genetic, hormonal, nutritional, or topical applications interference or an impact of unpredictable reactions.
- Individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections. Bacterial, fungal and viral infections can occur. Herpes simplex (viral infections) around the mouth can occur

following a treatment. Should any type of skin infection occur, check with your physician for proper treatment.

- Allergic Reactions: In rare cases, allergies to tape, preservatives used in cosmetics, topical preparations, etc. have been reported. Systemic reactions (which are more serious) may result from prescription medicines.
- **Compliance with the aftercare guidelines is crucial.**
- Occasionally, **unforeseen mechanical problems may occur** and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

**Do not accept advice from anyone not directly responsible for your post care. Suggestions from friends may be sincere, but are often not helpful or even innocently harmful.**

### **ACKNOWLEDGEMENT**

I have read and understand all of the above. I have asked any and all questions that I have regarding the procedure of laser lipo/ultrasonic cavitation, **pre-treatment and post-treatment**. I was given written instructions for **post-treatment** care at home. I understand completely and will take full responsibility for post-treatment care. All of the treatment fees have been discussed with me and I understand them completely.

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release **all related staff** from all liabilities associated with the above-indicated procedure. By signing this form, I am giving ComplexCity Spa permission to treat me, and I understand all symptoms and side effects that may occur during or after treatments, thereby releasing ComplexCity Spa of all liability regarding these issues.

***Should you have any concerns or questions, please do not hesitate to call our office. Our main goal is client satisfaction. That is why it is VERY important to educate our clients so they will fully understand the procedures of Ultrasonic cavitation and have trust, confidence and cooperation in their decision.***

We provide each client with full consultation, before treatment, and information of pre and post care necessary to achieve the best results possible.

All clients **MUST** sign this Consent Form indicating that they have read all of the pre- and post-treatment instructions, which are also discussed during consultation. The consent form is an agreement with the client that he/she is agreeing to be treated and that the client fully understands all pre- and post-treatment instructions as well as possible symptoms and/or side effects and skin reactions that may occur due to treatment. These symptoms and side effects include: diarrhea, headaches, toothaches if client has metal teeth fillings, bruising, ringing in the ears, kidney failure, liver failure (e.g. fatty infiltration of the liver), carrying a pacemaker or other electronic devices, pregnancy, lactation, hypertriglyceridemia, or hypercholesterolemia. These symptoms and side effects are normal and cannot be predicted. All side effects vary with each individual.

I understand that only the physician or technician can decide if treatment is **NOT appropriate** for the following reasons:

- Presence of metallic prosthesis
- Acute inflammatory processes
- Tumors or cancer
- Cutaneous lesions
- Proximity of the organs and the bone marrow
- Pace maker, high blood pressure or heart problems
- Pregnancy / breastfeeding
- Epilepsy
- Metal plates in your body
- Gall stones

- Active infections, hives, herpetic lesions, or cold sores
- Medications
- Extreme sensitivity or allergic reactions in the treated area
- Kidney damage, liver damage or diseases
- Hemorrhagic disease, clotting or bleeding
- Medical plastic parts or parts with meal inside
- Abnormal immune system
- Numb or insensitive to heat

If I mislead the physician, technician or student for any of the reasons mentioned above, by signing below I fully understand and take responsibility for the post-treatment consequences.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

Should you have any concerns or questions, please do not hesitate to call our office. Our main goal is client satisfaction. That is why it is VERY important to educate our client so they will fully understand the procedures of skin resurfacing and have trust, confidence and cooperation in their decision.

### **ARBITRATION AGREEMENT**

- I understand and agree that any dispute concerning medical malpractice will be determined by arbitration; the term medical malpractice interpreted broadly and shall include any and all claims in tort, contract, lack of informed consent or other legal theories which in any way pertain to claims or unnecessary, unauthorized, improper, negligent, or incompetent rendering of medical treatment.
- I understand that I am giving up my rights to bring a lawsuit or to resort to any court process except as Florida Law provides for judicial review of arbitration proceedings.

By signing this Agreement, I agree to resolve all disputes by arbitration rather than through the court.

- I understand and agree that this Arbitration Agreement binds me and anyone else who may have a right to assert a claim on my behalf or make a claim as a result of injury to me. I also understand that if I sign this Agreement on behalf of someone else, I am binding to this Agreement.
- I understand and agree that this Agreement relates to claims against the physician/technician and all consenting substitute physicians/technicians, their partnerships, professional corporations, employees, heirs, assigns or successors in interest.

I understand that this is a legal document and I have been advised of my rights to obtain legal counsel before signing this Agreement. By signing I fully understand this Agreement contains all the terms and conditions relating to Arbitration.

- I understand that I am forfeiting my rights to any trial. The damages awardable at arbitration are limited to those available under Florida law.
- Within fifteen (15) days after a party to this agreement has given written notice to the other of demand for arbitration of a dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.
- Expenses of the arbitration shall be shared equally by the parties to this agreement.
- Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes s. 682.01 et. seq.
- Any party to this agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and

render a binding decision without the participation of the party opposing arbitration or despite its absence at the arbitration hearing.

I understand that my request for arbitration concerning alleged medical malpractice must be made within the statute of limitations for filing any claim of malpractice as provided by Florida law and failure to seek arbitration within the applicable statute of limitations will forever prevent the submission of any claims.

- The patient has the right to rescind this agreement by written notice to the provider of medical services within three (3) days after the agreement has been signed and executed. The patient may rescind by merely writing “cancelled” on the face of one of his/her copies of this agreement, signing his name under such word, and mailing, by certified mail, return receipt requested, such copy to the provider of medical services with such three (3) day period.
- With respect to any dispute or controversy that is made subject to arbitration under the terms of this agreement, no suit at law or in equity based on such dispute or controversy shall be instituted by either party, except to enforce the award of the arbitrators.

### **Initial Please**

\_\_\_\_\_ I have provided my past and current medical history and medications.

\_\_\_\_\_ I consent to the taking of photographs during the course of my laser therapy for healthcare records.

\_\_\_\_\_ I consent to using my photographs for medical education and/or marketing purposes. My name will not be used to identify these photographs.

\_\_\_\_\_ I am not pregnant or nursing.

\_\_\_\_\_ I have been given the opportunity to ask questions about the procedure.

My questions have been answered and I understand the information given to me.

\_\_\_\_\_ Contraindications to the performance of this procedure have been discussed in detail with me.

\_\_\_\_\_ I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.

\_\_\_\_\_ I have read and understood all information presented to me before signing this consent form.

\_\_\_\_\_ I hereby release all related staff from all liabilities associated with the above-indicated procedure.

\_\_\_\_\_ By signing this form, I am giving ComplexCity Spa permission to treat me, and I understand all symptoms and side effects that may occur during or after treatments, thereby releasing ComplexCity Spa of any liability regarding these issues.

\_\_\_\_\_ **24 HOURS CANCELLATION POLICY** Confirmation of your appointments is a courtesy call not an obligation. It is the client's full responsibility to keep track of his/her scheduled appointments. If client fails to notify of appointment cancellation at least 24 hours in advance, the no-show will be counted as used treatment of the client's package deal or \$40.00 fees must be paid to accommodate the licensed technician time. For any credit card payments, a 10% surcharge and merchant fee will be deducted in case of any refunds 14 (fourteen) days after original transaction.

\_\_\_\_\_ **PACKAGE REFUND POLICY.** By signing this No Refund Policy, I am agreeing that any service(s), service package(s), gift certificate(s), and/or retail product I purchase(s) at ComplexCity Spa is a final sale. I understand any and all services(s), service package(s), gift certificate(s), and/or retail product(s) purchased will not be refunded or issued a credit. I also understand that if I decide to cancel or postpone any service(s), service package(s), gift certificate(s), and/or retail product(s), I will forfeit all monies paid; including any deposits and/or payments I have already paid.

I acknowledge being given a copy of this Agreement at the time it was signed.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Full Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Full Name \_\_\_\_\_