

Beautiful Body Contouring

New Client History

Name: _____ Date: _____

Address: _____ Birth Date: _____ Sex: M F

City: _____ State _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Occupation _____

How did you hear about us? _____

What is your main area(s) of focus/your problem area(s) _____

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, or have you had, any changes in medical history recently? Yes No

Explain: _____

Do you have Hearing aids, Pacemaker or Hormone Pellets (where) or metal/medical devices implanted? Yes () No ()

Explain: _____

Do you have type 1 or 2 Diabetes? Yes () No ()

List all current Medications including Vitamins _____

Do you have or have you had Cancer in the last 12 months? Yes No

If yes, are you currently on chemotherapy? Yes No

Do you have a Thyroid Problem? Yes No

Do you have High Blood Pressure or a Cardiovascular conditions? Yes No

Women Only, are you currently pregnant or nursing? Yes No

Please give us your current Weight _____ Height _____

What is your Ethnic Background? _____

Circle which applies to you: Epilepsy Infections Tumors Skin Diseases

Loss of Normal Skin Sensation

Thrombosis/Phlebitis

Autoimmune Disease

Neck/Back Problems _____

Gallbladder Removed Y N History of Gallstones Y N History of Liver Problems Y N

Are you currently dieting? Explain _____

History of Colon problems including protruding/distended belly? Y N

Explain: _____

Have you had any surgeries? _____

Typical Daily foods and drink intake?

Water: How Many Glasses _____

Coffee: _____

Alcohol: How Much _____

Fast Food: type _____ How Often _____

Soda or Carbonation: Type _____ How Often _____

Tobacco Use _____ Recreational Drugs (narcotics) _____

Stress Level: Moderate Y/N Average Y/N Demanding Y/N

I (print name) _____ consent to allow the Beautiful Body Contouring staff members to consult with & evaluate me in order to determine if I am a good candidate for the Non-surgical Body Contouring Program. I understand that photographs and measurements will be taken and kept in my file.

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

Signature _____ (if minor, parent's signature)

Date _____

BEAUTIFUL BODY CONTOURING, INC.

8595 East Bell Road, Suite D-101

Scottsdale, Arizona 85260

Office: 480.247.8660

Cell: 480.239.7090

Cancellation Policy

If there is a need to cancel for any reason, we ask for a 24 hour notice. Please understand that when you do not cancel or show up for a appointment, it is a cost to us. If you cannot provide us with a 24 hour notice we will have to 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

I, _____, have read and understand the cancellation policy of Beautiful Body Contouring, Inc. and agree to abide by the above conditions.

Signature

Date

Beautiful Body Contouring Consent Form

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480-247-8660

Body sculpting increase flow of both the lymphatic and circulatory systems, and it also helps with cleaning of the tissues. The main use 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 results. There should be at least 3-4 days between each treatment. This is not a weight loss treatment, but an inch loss. The inches will only return if the patient goes back to their old habits. Eating the right types of food, proper exercise and drinking 8 glasses of water per day are always recommended. For best results, it is recommended that you exercise within 4-6 hours of treatment and avoid sugar 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. We strongly suggest that you start on our liver cleanse and Plexus Slim and Accelerator. The liver cleanse will assist the liver and lymphatic systems in removing any blockages, and the Plexus products will assist in balancing blood sugar, decreasing cravings, reducing appetite and converting fat to energy. This may help you add a weight loss component to your loss of inches. If you're interesting in using these products, they will be most effective if started at the same time that you begin your body sculpting treatments. Waiver: I understand that I am using the V-Pulse provided at Beautiful Body Contouring at my own risk. Should I sustain an injury while using the equipment, I agree to hold Beautiful Body Contouring harmless.

Acknowledgement: I understand and acknowledge that payments for the above services are non-refundable. By my signature below, I certify that I have read and understand the contents of this Consent Form for Beautiful Body Contouring. I further agree to provide Beautiful Body Contouring 24 business hour notice of change in appointment times, or I will forfeit a treatment off my package since we work by appointment only. There are no refunds if you are responding and decide to stop taking treatments. Should we feel the need to apply an Ultra Cavitation treatment and/or a 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 your Laser Lipo package. I understand that photos of my progress may or may not be used at times on the web site of Beautiful Body Contouring.

Patient Signature

Date

Beautiful Body Contouring

Your consultation & evaluation today will determine if you are a candidate for our services

Date _____

Name _____ Age _____ Birthday _____ Sex M F

Address _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Place To Reach You (circle one) Home /Work/Cell. May we leave a voice mail message for you? Yes No

How Did You Hear About Beautiful Body Contouring?

What is your main area(s) of focus/ your problem area(s)? _____

1. Typical Daily Foods And Drink Intake?

Water: How Many Glasses? _____

Coffee: How Many Cups? _____

Alcohol: How Much? _____

Fast Food: Type _____ How Often _____

Soda: Type _____ How Often _____

2. Do you struggle with weight loss? [] YES [] NO

3. What diets/treatments have you tried? _____

4. Are you on an exercise program? [] YES [] NO

What type and how long? _____

5. What do you currently do to control your weight? _____

6. What are your body goals? _____

7. What medications are you currently taking & why?

8. Do you have Type 1 or 2 Diabetes? [] YES [] NO

9. Do you have or have you had Cancer in the last 6-12 months? [] YES [] NO

If yes, are you currently on chemotherapy? Y N

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Service Agreement

The following provisions apply to the services to be performed for _____
(Client Name)

At Beautiful Body Contouring...

(1) SERVICES TO BE PROVIDED

The Office provides ultrasound, laser, and radio frequency treatments, nutritional supplements.
_____(Client Initials)

(2) PAYMENT

Payment in full is to be made prior to the start of any program at BBC. _____ (Client Initials)

(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 _____ body contour 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 in activities identified by the office as potentially counterproductive to the body & may necessitate additional treatments to those otherwise provided for in this Agreement. **Our office policy requires 24 business hour notice for appointment cancellation. Failure to do so may result in deduction of pre-paid visits.** _____ (Client Initials)

(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 mail, to the office. Such "notice of termination" shall discharge the office from all further obligations and/or duty to render care to the client. The office reserves the right to terminate this Agreement in its sole discretion and will not withstanding any other terms or provisions of this Agreement or SUPPLEMENT. _____ (Client Initials)

(5) NO REFUNDS IN THE EVENT CLIENT TERMINATES AGREEMENT

To encourage commitment and follow-through, Beautiful Body Contouring offers **no refunds**. No refunds will be made on nutritional supplements, or body contour treatments. There will be **no**

HIPAA PRIVACY RULE

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information only to those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature: _____ Date: _____

Print Name: _____