Lipo-Light Intake Form

Your success is our #1 priority.
Help us to help you achieve that success by filling out this questionnaire as completely as possible.

Name:_____Date:_____
Address:_____
Home #:_____ Work #:_____Cell #:_____
Email:_____Height:_____Weight:_____Age:_____Sex:_____
Marital Status:_____Education:_____College Degree:_____
Major:_____Occupation:_____Favorite Hobbies:_____
Do you enjoy your work?_____
Do you feel stress (explain)?_____
Are you currently under the care of a physician?_____
Do you exercise?_____ How often?_____What type?_____
Do you get angry often?_____Are you happy (if not, why)?_____
What worries you most?_____
What do you expect from your **Lipo-Light** treatment?_____
Why did you choose us for **Lipo-Light**? _____
If you were referred by one of our former clients, please tell us who we can send a Thank You note to:_____

Weight Loss:

How long have you been overweight?_____
How much weight have you decided to lose?_____
How many times have you failed at weight loss?_____
What methods failed to help you lose weight?_____
Does your weight problem make you physically uncomfortable (explain)?_____
Does your excessive weight limit you and your activities (explain)?_____
How many times a year do you diet?_____
Do you suffer from uncontrollable cravings (explain)?_____
Do you feel out of control?_____
Do you eat because of emotions (explain)?_____

Lipo Light Consent Form
Consent and Release Form

Name: (First) _____ (Last)_____ DOB _____

Program and Background

You have requested to be treated with the Lipo-Light LED light therapy manufactured by Innovative Photonics Ltd. This treatment is the application of a 635nm of LED light, which has been shown through extensive research to cause the fat within the adipose (fat cell) to leave the cell and accumulate in the interstitial space around the cells, the LED light used for this treatment has no effect on tissue. Instead, the non-invasive LED light helps the body break down fat by stimulating its biological function. Excess fat is then removed naturally by the body's lymphatic system and subsequently excreted without the negative side effects and downtime associated with more invasive procedures such as liposuction. Any medical or cosmetic procedure carries risk, complications and varied results as to the effectiveness of a particular treatment. The purpose of this document is to make you aware of the nature of this product and its risks in advanced so that you can decide whether to go forward with this procedure.

Procedure

Initially you will consult with the therapist to determine if you are a candidate for the Lipo-Light LED therapy. During this time you will have the opportunity to ask questions or voice concerns you may have regarding this treatment. If it is determined you are a candidate for this procedure, there will be a few preliminary steps consisting of: initial paperwork, measurements, pre and post treatment photos and suggested course of treatment. The treatment will be administered by placing up to 16 Lipo-Light LED paddles on the desired area(s) to be treated. It is recommended that a patient will need a minimum of 8 treatments for the Lipo-Light LED therapy to achieve its desired effect. This treatment should be used in conjunction with a healthy diet and exercise. If you are not currently exercising you should consult a health care professional before beginning an exercise program to determine if your body is physically able.

Risks/Discomfort

This treatment is non-invasive and uses LED Light paddles with 30 diodes per paddle. During treatment there should be no discomfort, the client will feel the warmth of the light and the tightness of the bands holding the paddles. If for any reason during treatment that the client feels discomfort due to the warmth of the paddles, paddles should be removed immediately. Client should report this discomfort to clinician immediately. If paddles are left on client after client has reported this discomfort, it is at the client's own risk and provider assumes no responsibility. Lipo-Light is suitable for anyone over 18.

Anyone suffering from the following would **NOT** be suitable for this treatment:

- pregnant
- HIV – AIDS
- hepatitis C/D
- active cancer
- heart disease (not under the control of a physician)
- heart/pacemaker
- autoimmune disease (not under the control of/or monitored by a physician)
- thyroid problems (not controlled by medication)

Benefits

Over the years the benefits of LED Light therapy have become more prominent. LED Light therapy has been used in many studies for pain management and recently by cosmetic surgeons to emulsify adipose before liposuction with FDA approval. The potential benefit of this treatment is body contouring without surgery. Problem areas or excess pockets of fat can be targeted, however the most commonly treated areas are the stomach, hips, flanks, and thighs. In clinical trials patients have averaged 2-5cm lost from there stomach, hips, and thighs. These results do vary and no guarantee is implied or suggested that desired results will be achieved.

Alternatives

This is a strictly a voluntary cosmetic procedure. No treatment is necessary or required and the Lipo-Light LED therapy has been chosen by the client.

Questions

By signing below, you certify that this procedure has been explained to you and your satisfaction. Any further questions can be directed to a Beach Body Contouring therapist.

Consent

I have reviewed this consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form I grant authority for Hardison Family Chiropractic to perform the described treatment. The purpose of this procedure, risks, complications, alternative methods of treatment have been fully explained to my satisfaction. Cosmetic indications for these procedures include but are not limited to cellulite reduction, treatment of problem fat areas, skin tightening, and skin rejuvenation. You may experience increased redness to the area for up to 12 hours. You will be able to return to normal activities following the treatment. Any photos taken will be used to show the clients progress and may be used in marketing ads.

I have been informed of the potential risks and side effects of Lipo-Light including but not limited to redness, swelling, heat sensitivity, pain, increase bowel movements and increased urination. The risks, potential damages and adverse side effects have been explained to me and I fully understand.

_____Initial

I understand that a minimum of _____is required to achieve full results. At that point, I will be re-evaluated to see if more sessions are needed in order to achieve realistic goals. Each body is different and may require more or less treatments depending on the clients diet, exercise, metabolism and body type. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program. I know that if after the treatment course I gain weight, the results of the Lipo-Light may be reversed.

_____Initial

No guarantee has been given by anyone as to the results that may be obtained by this treatment. I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information and feel I am sufficiently advised to consent to this procedure. I hereby give my consent to have this procedure.

If at any time during the Lipo-Light procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/ or terminate the session at my discretion. The undersigned assumes all responsibility for behavior of self and their clients and agrees to abide by all Rules and Procedures of the property. The clients and all persons on the premises by invitation of the clients hereby hold Hardison Family Chiropractic, its employees, the LLC or any individual connected in any way to Hardison Family Chiropractic, harmless for any responsibility or liability for any accident, injury illness or damages sustained by or to any person or their personal property during their treatment appointments or use of facilities. Hardison Family Chiropractic shall be indemnified and held harmless by the clients, and clients agree to pay all costs incurred in connection with any accident, injury illness or property damage loss, including attorney's fees, regardless of how it may have occurred.

The undersigned hereby releases and indemnifies Hardison Family Chiropractic and holds harmless any employee, the LLC or any individual connected in any way to Hardison Family Chiropractic for any loss of personal property and/ or accident causing personal injury of any nature, including reasonable attorney's fees and court costs in connection therewith.

Name: (First) _____ (Last) _____ **Date** _____

I further state that I am of lawful age and legally competent to sign this aforementioned release; I understand the terms herein is contractual and not a mere recital; I have signed this document of my own free act.

At Hardison Family Chiropractic we place the highest priority on the client's right to privacy. Our office staff is trained to protect our private health information. We value your privacy, and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. We do not disclose identifiable information to any third party without your consent. Further, we do not sell, rent, or otherwise allow the unauthorized outside use of personal information such as names, addresses, phone numbers, or e-mail addresses in our database without your permission. Copies of this form and signature will be valid as if original if this document is digitally scanned.

I have explained the procedure, alternatives, and risks to the person or persons whose signature is affixed below. The patient has verbally communicated to me that they understand the contents of this form.

_____ _____

Signature of Therapist Date

T Zone Disclaimer 2016

Name_____

Date _____

Please be advised that the Whole Body Vibration Platform Device is being used for the purpose of rehabilitation and other health benefits. If you have any of the following diagnosed conditions, please discuss with a Doctor:

Cardiovascular conditions	yes	no
Pacemaker	yes	no
Pregnancy	yes	no
Hip, Knee or shoulder implants	yes	no
Epilepsy	yes	no
Severe Diabetes	yes	no
Acute hernia, discopathy, or spondylolysis	yes	no
Recent infections	yes	no
Tumor	yes	no
Recently placed IUD's, metal pins or plates	yes	no
Herniated spinal disc	yes	no

If you answered "Yes" to any of the above conditions, please explain:

_____

_____

_____

I understand that I may be able to use the Whole Body Vibration Device even though I have marked "yes" to any of the above conditions. I further understand that I use the Whole Body Vibration Device at my own risk.

_____

Signature

_____

Date