Laser Light Client Intake Form

PLEASE PRINT LEGIBLY

Name _____ Email _____

Address _____ City/State/Zip _____

Phone: Home _____ Cell _____

Please take a moment to read and initial all of the following statements:

I understand that if I arrive late to an appointment, my time on the Laser Light machine may be shortened by the amount of time I was late.

_____

If I need to cancel or reschedule an appointment, a 24 hours notice is required. Should I give less then the required notice, the missed appointment may be counted as a completed treatment.

_____

If I fail to show up for an appointment, all future appointments that had been previously scheduled will be cancelled and will need to be rescheduled.

_____

I understand that I am expected to exercise after each session. Moderate physical activity is best.

_____

Client Treatment Consent Form

I duly authorize the practitioners of Lifecare Chiropractic to perform the Lipo-Light procedure for the purpose of spot fat reduction / improving the appearance of cellulite. I am aware that clinical results may vary depending on individual factors, including medical history, client 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 dietary requirements and exercise, I am aware that the results achieved may not be retained.

I understand the treatment 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 outstanding treatment value is non refundable.

I certify that I have been fully informed of the nature and purpose of the 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 understand that it is my personal responsibility to inform the practitioner of the clinic named above of any changes to my medical history during the course of Lipo-Light treatment sessions and I confirm that should this occur I shall advise the practitioner of any changes.

I certify that I have been given the opportunity to ask questions, any questions have been answered to my satisfaction and that I have fully read and understood the contents of this consent form.

Client Name _____

Client Signature _____ Date: _____

Practitioner Signature: _____ Date: _____

Contra-indications for i-Lipo Treatment

The following conditions should not undertake laser or light based treatments.

I confirm the following by checking the applicable box:

- ☐ **I am not under the age of 18**
- ☐ **I am not pregnant or lactating**
- ☐ **I do not have cancer or a history of cancer**
- ☐ **I do not have a pacemaker or Implantable Cardioverter Defibrillators**
- ☐ **I do not have liver, kidney disorders or cardiac/circulatory disorders**
- ☐ **I do not have uncontrolled hypertension**
- ☐ **I do not have an active infection, lymphatic disorder or autoimmune disorders**
- ☐ **I do not have Type 1 Diabetes**
- ☐ **I do not have a known photosensitivity to sun exposure or are taking drugs that cause photosensitivity**
- ☐ **I do not have any known thyroid gland dysfunctions**
- ☐ **I am not epileptic**
- ☐ **I do not have any open wounds or skin infections**

Included in your purchase of a laser liposuction package, we will provide you with before and after images and measurements to track your progress. Some patients, however, are not interested in this process.

_____ Yes, I would like measurements and pictures taken

_____ No, I would prefer to monitor my own progress.

I hereby certify that all information that I have provided has been accurate and truthful.

Patient's Printed Name: _____

Patient's Signature: _____

Date: _____

Progress notes

Patient: _____

Date	Location of therapy	Duration of Tx	Measurement(s)	Responded well to Tx	Comments	Dr. Signature
				Y / N		
				Y / N		
				Y / N		
				Y / N		
				Y / N		
				Y / N		
				Y / N		
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