



Client Waiver

Name:

Address:

City:

Province/State:

Postal/Zip Code:

Phone #

Email:

1. Check if you have or had any of the following, if yes briefly explain:

Pregnant

Breast Feeding

Bleeding Disorders

High Blood Pressure

High Cholesterol

Liver Disorders

Diabetes

Metals in Body

Other: _____

Cardiac Disorders

Lymphatic Disorders

Psychological Diagnosis

Skin Disorders

Respiratory Disorders

Pace Marker or Devices in Body

Seizures

Cancer

2. Describe any surgeries you've had in the last 6 months:

3. List any allergies:

5. List any medical or non-medical condition your technician should be aware of:

6. Specific Appearance problems and treatment goals:

7. Current weight and height _____

I understand that certain procedure(s) elected are relatively new and little is known about their long-term safety and effectiveness. I understand that each person has a different response to Body Contouring.

I understand that the procedure(s) do not correct health problems, including but NOT limited to diabetes, heart attack, stroke, high cholesterol, blood clots, lung problems, stomach, intestinal problems, bladder disease, an abnormality of the skin. You must consult with your Primary Care Physician for medical advice.

I understand that I may need post procedure care. I will dutifully be responsible and compliant with the recommendations from my Specialist, which may include, but are not limited to skin care products, garments, etc.

I understand that procedures involve risk. Risk may include, but not limited to redness, swelling, irritation, burns, skin reactions, etc. I must immediately report any unusual symptoms known to me to my Specialist that includes, but NOT limited to being aware of any slight nature or prominence of persistent chills, fever, redness, increased warmth, excessive bruising or swelling, etc. at the sights treated and systematically.

I give permission to use data about my treatment for research purposes. I understand that my name and personal identifying information will remain confidential unless I have written permission to disclose this information.

I have decided that the benefits of body contouring outweigh the potential for complications and all claims have not been evaluated by any regulatory board. I understand the nature of the procedure(s) and ANY and all possible risks mentioned and not limited to. I attest that I am of clear mind, competent, and not under any distress.

RELEASE OF LIABILITY

I hereby certify that I am not pregnant or nursing.

I understand that **NO GUARANTEES OR WARRANTIES** have been made to me regarding the outcome or any improvements to my condition due to the procedure(s) I have elected to undergo. I am paying for a service and not desired results from treatments. I have been given the opportunity to ask questions and have received satisfactory answers to those questions by the treating staff representative. _____ **(Initial)**

I agree to indemnify, hold harmless and release _____, its employees, members, representatives, affiliated organizations, and others acting on the Sculpted515's behalf of all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated. I further agree that except in the events of the Company's gross negligence or willful misconduct, no claims, demands, legal actions and causes of action shall be made against Sculpted515 for any economic and non-economic losses of any kind. _____ **(Initial)**

Finally, I certify that I have read and fully understand the contents of this form and that the disclosures referred to the above were made prior to my signing the form below.

_____ **(Initial)**

Refund Policy

Due to the nature of the service refunds are not given, please contact us should any issues arise after your service.

By signing below I agree to the following;

I have completed the form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the establishment for any injury or damages incurred due to any misrepresentation of my health.

Client Name (Print)

Client Signature

Technician Signature

Date

Package purchased: _____

Price and pay agreement: _____

Notes: _____

Photo and video release form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area. Photographic, audio or video recordings may be used for the following purposes:

- *educational presentations or courses*
- *informational presentations*
- *on-line educational courses*
- *educational videos*
- *promotional materials*

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only. By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name _____

Signature _____ Date _____

