



Patient (Client) Intake

Last Name, First Name: _____ Date: _____

Address: _____

Date of Birth: _____ Age: _____ Phone Number: _____

Email: _____

Type of Procedure: _____

Have you ever used Body Sculpting Equipment: _____

What is the motive for your visit? What is your expectation: _____

Cardiac Condition: _____ Lupus: _____ Diabetes: _____

Contact Allergies: _____ Hemophilia: _____ Skin Diseases: _____

Open Wounds: _____ High or Low Blood Pressure: _____

History of Herpes: _____ Current Medication: _____

Screws or other metals: _____ Varicose Veins: _____

Are you taking medications: _____ Are you Breastfeeding: _____

Are you taking diet pills: _____ Any other health conditions not listed: _____

Are you under a doctor's care: _____ Active Cancer: _____

Do you have any circulatory or respiratory problems? _____

Have you had any surgical operations recently? _____

Do you smoke: _____ Are you pregnant: _____

I understand that I am doing Body Sculpting Treatments at my own risk. I understand that the management of this establishment and its employees assume no liability of any kind. I have been informed of the treatment I am about to undertake, and I have been honest about my health and well-being. I confirm that I will inform My Aspiration Spa if any changes in my health occur during treatment.

Signature

Date



Client Contract

Please read through all items below and initial next to each one.

_____ I understand that the procedure can result in an appearance enhancement and is typically used for small, stubborn, pockets of fat. The treatment involves the use of cavitation, vacuum therapy, radiofrequency, thermal wraps, wood therapy, lipolaser to break down fat in the subcutaneous layers.

_____ I understand that I may require a series of treatments, normally with at least two-four days between procedures, to achieve the maximum cosmetic result.

_____ I understand that Body Sculpting treatment carries with it possible health complications and consequences, which include but might not be limited to the risk of kidney failure, liver failure, pacemaker failure, miscarriage, thyroid damage, hyper-triglyceridemic, hypercholesterolemia, pancreatitis, or allergic reaction to any products used, excessive thirst, dehydration. Nausea may also be a side effect of the treatment.

_____ I acknowledge that no written or implied verbal guarantee, warranty or assurance has been made to me regarding the outcome of the procedure.

_____ I understand that individual results may vary. No guarantees are made in regards to the expected outcomes of this procedure. I am happy to proceed with this treatment.

_____ I give full consent to the use of my before and after images for marketing purposes, providing all identifying features are covered and that there is no way to identify myself from the image. Images will be kept for 6 years and may be used in the event of a claim being brought against us. They will be stored on a password encrypted hard drive.

_____ I understand that I have full access to all data held on me. This data will be held by the clinic for no longer than 6 years for insurance purposes, after which, digital information will be deleted permanently, and paper documents will be destroyed. All information on myself is kept on password encrypted hard drives or locked in filing cabinets to which only selective staff members have access. None of my personal data will be sold or used for anything other than to provide the services of this clinic.

_____ I acknowledge that all information I provide on my medical history form is true and therefore believe that I am physically capable of participating in My Aspiration Spa treatment. I will report any significant health problems that may occur during the course of the program.

_____ I understand that the treatment is a medical condition program. I understand the risks of any service received by My Aspiration Spa. I also understand that I cannot expect results in a single session; results can sometimes be noticed and achieved within 6 to 12 sessions.

_____ I am aware that My Aspiration Spa does not diagnose any medical condition. I understand the risks of any service received by My Aspiration Spa, including but not limited to any bodily injury and skin reactions. Explain that the treatment can cause moderate pain. My Aspiration Spa releases any liability as a result of any of their treatments received.

_____ I am aware that all files, photos and measurements are the property of My Aspiration Spa and I give My Aspiration Spa permission to publish statistical data and photos taken during the course of the program.

_____ I understand that My Aspiration Spa has a strict 24-hour cancellation policy and if I have to cancel an appointment within 24 hours of the scheduled time, I am responsible for paying the entire session.

_____ I am aware that each security measure will be carried out by staff and may include refusal of my treatment if considered unsafe.

_____ I understand that I must follow the diet plan prepared by My Aspiration Spa and that failure to follow the diet plan may restrict the weight loss potential of the slimming program.

_____ I am aware that the initial payment, which is used for the consultation, photos, diet plan, and the first six treatments will no longer be refundable.

_____ I agree that if I use any equipment or facilities on the premises (including the parking lot) that I do so at my own risk. I agree that I am voluntarily participating in the activities on the premises and assume all risk of injury, illness, damage or loss to myself or my personal property. I agree to release, I discharge without fault My Aspiration Spa (and its affiliates, employees, independent contractors, agents, representatives, successors, and assigns) from any and all claims or causes of action (known or unknown) arising from arise from their negligence. I acknowledge that I have carefully read this waiver of any right I may have to bring legal action to pursue a claim against My Aspiration Spa for her negligence.

_____ I, as a client of My Aspiration Spa, understand and agree that any information you have given me is free from My Aspiration Spa, its employees, or associated for-profit entities. I also understand that I cannot give any detailed treatment information that may be considered "trade secrets" to anyone at all. My Aspiration Spa reserves the right to take any legal action it deems necessary against you and/or any associate for the misuse of this valuable information.

_____ You agree that in the event that any clause or provision of this Agreement and the Release are held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not affect the other remaining provisions, that which will continue to be required. This Agreement shall be governed by and construed in accordance with the laws of California. Any controversy or claim arising out of or relating to any service I receive to My Aspiration Spa shall be resolved by binding arbitration in the County of San Bernardino, administered by the Center for Judicial Mediation and Arbitration ("JAMS")

_____ I am aware of and fully agree with the terms and conditions.

_____ I confirm that to the best of my knowledge that the information that I have supplied is correct and that there is no other medical information I need to disclose.

_____ I understand that treatments and products is not an exact science and therefore that no guarantee can be given as to the results of the treatment referred to in this document. I accept and understand that the goal of this treatment is improvement, not perfection, and that there is no guarantee that the anticipated results will be achieved.

_____ I have been fully informed and understand the use of the My Aspiration Spa and accept personal responsibility for my treatments. I understand that My Aspiration Spa and its staff are not liable for any injury to person caused in any way by the use of its services or premises. I hereby authorize My Aspiration Spa and to take photographs of me to use them as an aid to my treatment. I am aware that the results achieved by this treatment may vary from person to person, and I acknowledged that no promises or guarantees have been made to me as to the results of this treatment.

Patient (Client) Name :

Patient (Client) Signature

Date

Practitioner Signature

Date