AcuLaser
TREATMENT CENTRE

The following information is required prior to beginning your therapy. All information is confidential. E-mail is used solely for follow-up support and will not be sold to third parties.

******* LIPO LASER CONSENT *******

Date:	**First Name:**	**Last Name:**
Address:		**City:**
State	**Zip Code:**	**Telephone:**
E-mail:		

I duly authorize AcuLaser Treatment Centre to perform the Lipo Laser PLUS Evolution procedure for spot fat reduction and improving the appearance of cellulite. I understand that individual results may vary depending on factors including, but not limited to medical history, client compliance with pre/post treatment protocol, and individual response to treatment. I am aware that my eating habits and amount of exercise I do will have a major impact on the results of my treatment and that results may not be long term if I do not address these concerns.

INITIALS: _____

I understand the procedure involves a course of several treatments. The fee structure has been explained to me and I am aware that I will be required to pay for my treatments in advance. I also understand that in the event I wish to cancel my Lipo Laser treatments, payments already made are non-refundable. I certify that I have been given the opportunity to ask questions, and that any questions I did ask were answered to my satisfaction.

INITIALS: _____

I certify that I have been made fully aware of nature of the procedure, possible outcomes or complications, and that no guarantee can be made as to the result I obtain from this treatment. I understand this is a cosmetic only procedure and that the decision to proceed is based solely on my desire to do so. I also understand that no medical claims are made implied.

INITIALS: _____

I should notify AcuLaser Treatment Center of any changes in my health or medical history during the treatments. I consent to having before and after photographs taken and used anonymously for evaluation, education and promotion. I have fully read and understand the contents of this Lipo Laser consent form, and I further agree that all the information I have disclosed, both medical and non-medical is true and accurate.

I agree to not hold AcuLaser Treatment Centre responsible for any liability arising from or related to information I may have inaccurately provided prior to this procedure.

Print Name: _____ Date: _____

Signature: _____ Date: _____

Technician: _____ Date: _____

Please check if you have had or are currently experiencing any of the following:

- ☐ **Epilepsy**
- ☐ **Diabetes**
- ☐ **Medical Edema**
- ☐ **Kidney problems**
- ☐ **Auto Immune disease**
- ☐ **Thyroid issues**
- ☐ **HIV or Communicable disease**
- ☐ **Muscular or Skeletal issues**
- ☐ **Dermatitis, Eczema, Psoriasis or other skin disorders**
- ☐ **Bladder infection**
- ☐ **Cancer:** _____
- ☐ **Hormone replacement**
- ☐ **Gastric ulcers**
- ☐ **Infection or Fever**
- ☐ **Cardiovascular disease**
- ☐ **Pacemaker or other Metal implants**
- ☐ **Digestive problems**
- ☐ **Other:**_____

If you have answered yes to any of the above, please explain:

_____

_____

_____

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you currently on any prescription medication? ☐ Yes ☐ No If yes, please list:

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Drug: _____ Reason: _____