Bella Contours ~ Body Sculpting Medical Form

Name:	Email:	DOB:
Address:	City:	State: Zip:
Phone: (Cell)	Phone: (Work)	
Emergency Contact: (Name)	(Phone)	

Ultrasound Cavitation/ Radio Frequency Treatment/ Non-Surgical Butt Lift (Check all that apply)

___ Face and Neck ___ Arms ___ Upper Back ___ Lower Back
___ Abdomen ___ Waist (love handles) ___ Hips (Saddle Bags) ___ Butt Lift
___ Front of Thighs ___ Back of Thighs (hamstrings) ___ Inner Thighs ___ Calves

Medical Background Check if your answer is **"YES"** to any of these questions below.

- ☐ Are you pregnant or nursing?
- ☐ Are you epileptic?
- ☐ Do you have any kind of tumor or cancer?
- ☐ Do you have any cardiac or vascular disease or condition?
- ☐ Do you have any acute inflammation?
- ☐ Do you have a wound that is not healed?
- ☐ Do you have any current or history of internal bleeding?
- ☐ Do you have a pace maker or other electronic device?
- ☐ Do you have any plastic or bone cement or any large metal implant?
- ☐ Have you have any abdomen operations?
- ☐ Do you have abnormally high or low blood pressure?
- ☐ Do you have high levels of Triglycerides (hereditary)?
- ☐ Are you allergic to zinc or nickel?
- ☐ Do you have hemophilia?
- ☐ Do you have melanoma?
- ☐ Do you have thrombosis and/ or thrombophlebitis?
- ☐ Have you undergone a transplant?
- ☐ Do you have a Neurological Disorder?
- ☐ Are you being treated with anticoagulants?
- ☐ Do you have any keloid?
- ☐ Do you have any kind of heart trouble?
- ☐ Do you have any current infectious disease or tuberculosis?
- ☐ Do you have advanced untreated diabetes?
- ☐ Do you have a communicable disease?
- ☐ Do you have any type of heart, kidney and liver disease?
- ☐ Any other Medical conditions? Please List. ____

If you checked any of the above questions you may not be eligible for treatment. Please explain **"YES"** answers here:

____
____
____

Are you presently taking any medications? List:____
Are you allergic to any foods or medications? List: ______________________________________
Please explain any other current medical conditions:_____________________________________
Are you taking any vitamins/ supplements:____
Are you presently under a physician's care? What For? ____________________________________
Family or primary treating physician name and phone number:______________________________

Client Signature______________________________________ Date Signed____________________

Client Printed Name______________________________________

Accepted by Tech____

Bella Contours

Body Sculpting Consent Form

Disclosure. This treatment is a process and subsequent visits may be necessary in order to achieve the desired results. Subsequent visits are subject to additional charges per visit which depend on the amount of work needed. Actual results vary from person to person and Bella Contours does not guarantee any specific result. The Ultrasound Cavitation/Radio Frequency 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, birth defect, miscarriage, thyroid damage, damage to the ovaries, lactation complications, hyper-triglyceridemia, hyper-cholesterolemia, pancreatitis, infection, scarring and/or allergic reaction to any products used, excessive thirst, dehydration, nausea. The Ultrasound Cavitation/Radio Frequency treatment includes, but is not limited to, the use of high-power low-frequency ultrasound cavitation which uses 40KHz frequency ultrasound to penetrate the skin and assist with the breakdown of fat cells by creating micro-bubbles that increase the pressure around the adipocyte and force it to implode, thus breaking down the adipocyte's cell membrane. Radio Frequency treatments tighten skin. I also acknowledge that services such as Wood Therapy, vacuum Butt Lifts, Laser Lipo, Cavitation, Radio Frequency, Vacuum Drainage, will be performed and accept full responsibly for any and or all damages, injuries, irritation, bruising, swelling, rashes if they occur.

After Care. After care instructions must be followed explicitly, whether given in writing or orally. Failure to follow after care instructions may compromise the final results of the treatment.

Before, During and After Pictures. Before, during and after pictures or videos may be taken to document the treatment. These pictures or videos become Bella Contours sole property and may only be used for its legitimate business purposes.

Release. I recognize that there are certain inherent risks associated with the above-described treatment and I assume full responsibility for personal injury to myself. In exchange for such treatment, I hereby fully release and forever discharge Bella Contours (including its officers, members, owners, employees and agents) from any and all damages, costs, expenses, liabilities, causes of action, claims and demands, of whatever character, in law or in equity, whether known or unknown, direct or indirect, asserted or unasserted, and whether or not on account of myself, Bella Contours or other third parties, or in any way arising out of the above described treatment I have requested Bella Contours to perform. It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to the treatment or services provided by Bella Contours including any spouse or heirs of the client/patient and any children, whether born or unborn. Any legal or equitable claim that may arise from participation in the treatment shall be resolved under Texas law.

I agree to indemnify, hold harmless and defend Bella Contours (including its officers, members, owners, employees and agents) against all third-party claims, causes of action, damages, judgments, costs or expenses, including attorneys' fees and other litigation costs, which may in any way arise from the above described treatment I have requested Bella Contours to perform.

Arbitration. It is understood that any dispute arising as to malpractice of the Ultrasound Cavitation treatment shall be decided by a neutral arbitrator. Any arbitration proceeding will be governed by Texas arbitration statute, the fees for the arbitrator will be split pro-rata among the parties and each party will be responsible for their own attorneys' fees and costs. Any action to collect fees from the client/patient for the treatments performed may be brought in any court located in Texas and the prevailing party in such collection action shall be entitled to recover its reasonable attorneys' fees and costs. Filing of any action in any court to collect any fee from the client/patient shall not waive the right to compel arbitration of any malpractice claim.

By signing this agreement I confirm that I am over the age of 18, I understand that the Ultrasound Cavitation/Radio Frequency procedure stimulates permanent changes, that such procedure has possible adverse consequences and that the procedure is for cosmetic purposes only. I certify that I have read the above paragraphs, fully understand this consent and procedure form and herby consent to the indicated procedure(s). This means that I accept full responsibility for these and/or any other complications which may arise or result during or following the Ultrasound Cavitation procedure which is to be performed at my request according to this agreement and I herby agree to arbitration of any malpractice claim. I further understand that by signing this agreement, I surrender certain legal rights.

____________________________________ ______________________

Client Signature Date Signed

____

Client Printed Name

____

Accepted by Technician

Bella Contours

Refund and Cancellation Policy

All costs are payable in-full prior to initial treatment and are non-refundable. Package price (3 or more sessions) is payable in full at first package visit prior to treatment. Packages once purchased and with first treatment initiated are non-refundable.

Your appointment is not booked until we received a $45 non-refundable deposit that will go towards your total.

Please allow 24 hours for any cancellations or rescheduling. If you cancel/no show or reschedule the same day of your appointment your deposit will not be refunded. Also, your session will be subtracted from your purchased package.

Initials: __________We allow a 10-minute grace period. Being more than 10 minutes late will result in your appointment being cancelled. Your deposit will not be refunded. Also, your session will be subtracted from your package.

In the event this account is referred to an agency for collections or if an electronic check is returned, you agree to be responsible for all returned fees and any collection costs, including collection agency and/or attorney fees. By signing, I have read and understand the cancellation policy of Bella Contours and agree to abide by the above conditions.

______________________________ ______________________

Client Signature Date Signed

____

Client Printed Name

Bella Contours

Photo Release and Consent Form

In order to track our progress, we at Bella Contours like to incorporate the use of photos. It helps us to thoroughly see the changes in your body from beginning to end. Photos are to be used for documentation purpose, and if consented as advertisement for the product, and/or service etc.

I ____ do hereby agree to the following. I am allowing Bella Contours or delegated photographer to take photos of my treatment and/or treated areas to be used to the purpose of monitoring my progress and give my permission for Bella Contours to post any videos or photos of services performed on me and any relating descriptive information obtained on me to its social media sites including its website, Instagram and Facebook.

__________ I understand that such consent is voluntary.

__________ I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Bella Contours.

__________ I understand that once my photographs have been disclosed to Bella Contours, affiliates, successors and assignees the photographs will no longer be protected by federal privacy laws. However, Bella Contours affiliates, successors, and assignees will not use the photographs except as permitted on this authorization form.

__________ I understand that in some circumstances the photographs may portray features, which shall make my identity recognizable.

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

____ ______________________

Client Signature Date Signed

____

Client Printed Name

Bella Contours

After Treatment Care

Recommendations prior to starting your first session and during treatment process.

Prior to starting your first session we recommend you drink 2-3 liters of water. Water and hydration is key to this process being effective.

To maximize the effectiveness of your sessions, it is best to restrict products that impact lymphatic flow during the program. [caffeine, alcohol and sugar in large amounts]

We recommend eating a healthy diet to stabilize the fat and inches loss you obtain during the treatment. Always consult with your Physician before beginning any new Health & Diet Program. Always inform us if you have a change in health status or experience any unusual symptoms during your program.

We recommend additional daily exercise to stimulate lymphatic flow. This includes low impact workouts, brisk walking, swimming or cycling during this process. Adding this activity to your ongoing lifestyle will help to stabilize your weight and fat loss.

You can have Ultrasonic Cavitation during your Menstrual Cycle but it is recommended to avoid the abdomen as you may not see the immediate results, due to bloating. This may increase blood flow and cause a heavy cycle.

We concentrate on treatment of one body area during each session. “Time on Target” will achieve maximum results. Treatments can be done a minimum of 72 hours apart.

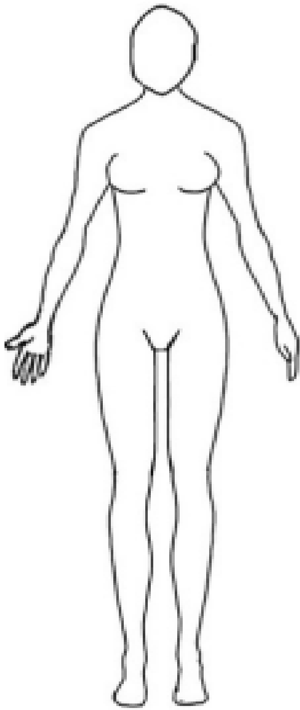
Tell us if your digestive process is affected in any way during a session. [constipation/diarrhea]

If you should become pregnant during this process please inform us immediately.

______________________________ ______________________
Client Signature Date Signed

____
Client Printed Name

Bella Contours ~ Treatment Intake Form



Client Name:____

Treatment Type:____

Area: arms, legs, chin, abdomen, waist, butt, hips, love handles, back, thighs

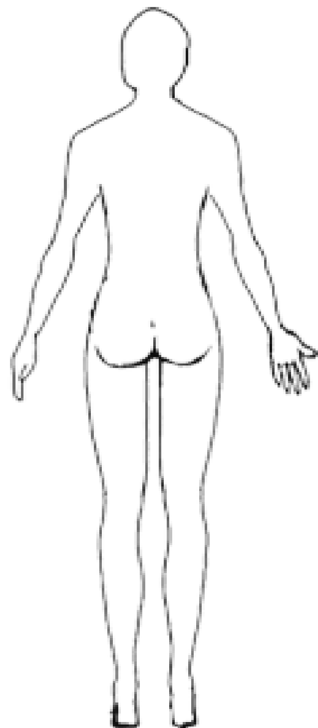
Number of Sessions:_____________

Total:______________Deposit:______________Due:_______________

Session 1.____________________________ Date ________________
Meas: Before:__________ After:__________ Check In:____________
Payment:______________ Balance:______________

Session 2.____________________________ Date ________________
Meas: Before:__________ After:__________ Check In:____________
Payment:______________ Balance:______________

Session 3.____________________________ Date ________________
Meas: Before:__________ After:__________ Check In:____________
Payment:______________ Balance:______________



Session 4.____________________________ Date ________________
Meas: Before:__________ After:__________ Check In:____________
Payment:______________ Balance:______________

Session 5.____________________________ Date ________________
Meas: Before:__________ After:__________ Check In:____________
Payment:______________ Balance:______________

Session 6.____________________________ Date ________________
Meas: Before:__________ After:__________ Check In:____________
Payment:______________ Balance:______________

Session 7.____________________________ Date ________________
Meas: Before:__________ After:__________ Check In:____________
Payment:______________ Balance:______________

____
Client Signature

By Signing: I agree that all information, payments, and number of sessions on this page are valid.