Client Information & Medical History

PERSONAL HISTORY:

Client Name ________________________________ Date ____________________

Home Address ____

Phone ________________________________ Email _______________________

How were you referred to us? ____

Area of desired improvement? ____

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MEDICAL HISTORY: Do you have any of the following medical conditions? (Please check all that apply)

- ☐ Pregnancy/Nursing
- ☐ Acute Inflammation
- ☐ Pacemaker or Other Electronic Devices
- ☐ Recent Abdominal Surgery
- ☐ Unhealed Wounds
- ☐ Lose Breath Easily
- ☐ Communicable Diseases
- ☐ Thrombosis
- ☐ Taking any Anti-Coagulants
- ☐ Heart Trouble
- ☐ Any Infections, Diseases, or Tuberculosis
- ☐ Kidney or Liver Disease
- ☐ Cardiac or Vascular Disease/Condition
- ☐ History of Internal Bleeding
- ☐ Plastic, Bone Cement or Metal Implants
- ☐ Abnormal High or Low Blood Pressure
- ☐ Epilepsy
- ☐ High Cholesterol
- ☐ Melanoma
- ☐ Transplant
- ☐ Keloids
- ☐ Current Infection
- ☐ Diabetes
- ☐ Migraines

Please list any medications:____

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Client Initials: _______________

PLEASE INITIAL EACH OF THE FOLLOWING:

_______ TREATMENT DISCLOSURE: THE TREATMENT IS A PROCESS AND SUBSEQUENT VISITS MAY BE NECESSARY IN ORDER TO ACHIEVE THE DESIRED RESULTS. ACTUAL RESULTS VARY FROM PERSON TO PERSON. INSTACULPTINGKC LLC, INSTASCULPTINGNB LLC (HEREINAFTER “INSTASCULPTING”) IN THE ZONE CRYO & HEALTH UPGRADES DOES NOT GUARANTEE ANY SPECIFIC RESULT.

_______ AFTERCARE: PATIENTS ARE RECOMMENDED TO DRINK AT MINIMUM 1.5 LITERS OF WATER ON A DAILY BASIS WHEN UNDERGOING THIS TREATMENT. IT IS ENCOURAGED TO COMPLETE A 30-45 MINUTE CARDIO WORKOUT AFTER THIS TREATMENT. AFTERCARE INSTRUCTIONS HAVE TO BE FOLLOWED EXACTLY WHETHER GIVEN IN WRITING OR VERBALLY. FAILURE TO FOLLOW AFTERCARE INSTRUCTIONS MAY COMPROMISE THE FINAL RESULTS OF THE TREATMENT.

_______ BEFORE, DURING, AND AFTER PHOTO: BEFORE, DURING OR AFTER PICTURES MAY BE TAKEN TO DOCUMENT YOUR TREATMENT. THESE PICTURES BECOME INSTASCULPTING SOLE PROPERTY AND ARE ONLY USED FOR LEGITIMATE RECORD KEEPING.

_______ **SOCIAL MEDIA/ PHOTO CONSENT:** WE WOULD LIKE YOUR PERMISSION TO USE BEFORE AND AFTER IMAGES TAKEN OF YOUR TREATMENT ON OUR WEBSITE, FACEBOOK PAGE, AND INSTAGRAM.

_______ **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 HEARBY FULLY RELEASE AND FULLY DISCHARGE INSTACULPTINGKC LLC, INSTASCULPTINGNB LLC (HEREINAFTER “INSTASCULPTING”) IN THE ZONE CRYO & HEALTH UPGRADES FROM ANY AND ALL DAMAGES, COSTS, EXPENSES, LIABILITIES, CAUSE OF ACTION, CLAIMS AND DEMANDS OF WHATEVER CHARACTER IN LAW OR EQUITY, WHETHER KNOW OR UNKNOWN , DIRECT OR INDIRECT, ASSERTED OR UNASSERTED AND WHETHER OR NOT IN ACCOUNT OR MYSELF OR INSTACULPTINGKC LLC, INSTASCULPTINGNB LLC, IN THE ZONE CRYO & HEALTH UPGRADES OR OTHER THIRD PARTIES WHOSE CLAIMS MAY ARISE OUT OF OR RELATED TO THE TREATMENT PROVIDED BY INSTACULPTINGKC LLC, INSTASCULPTINGNB LLC (HEREINAFTER “INSTASCULPTING”) IN THE ZONE CRYO & HEALTH UPGRADES. ANY LEGAL OR EQUITABLE CLAIM THAT MAY ARISE FROM PARTICIPATION SHALL BE RESOLVED UNDER THE STATE OF KANSAS AND/OR CALIFORNIA LAW.

_______ **RESULTS:** I AGREE THAT RESULTS ARE SUBJECTIVE AND THAT MY LIFESTYLE CAN MITIGATE THESE RESULTS; THEREFORE, THE COST OF THE PROCEDURES ARE NON-REFUNDABLE.

BY SIGNING THIS AGREEMENT, I CONFIRM THAT I AM OVER THE AGE OF 18. I UNDERSTAND THAT THE PROCEDURE IS PERMANENT, 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 THE PROCEDURES RISKS AND HEREBY CONSENT TO THE INDICATED PROCEDURES. THIS MEANS I ACCEPT FULL RESPONSIBILITY FOR THESE AND/OR ANY OTHER COMPLICATIONS WHICH MAY ARISE OR RESULT DURING OR FOLLOWING THE PROCEDURE, WHICH IS TO BE PERFORMED AT MY REQUEST. I FURTHER UNDERSTAND THAT THE COST OF THESE PROCEDURES ARE NON-REFUNDABLE AND THAT BY SIGNING THIS AGREEMENT, I VOLUNTARY SURRENDER CERTAIN LEGAL RIGHTS.

CLIENT/PATIENT ____

DATE: ____

INSTASCULPTING TECHNICIAN____

DATE: ____

CANCELLATION POLICY

INSTASCULPTING AND OUR STAFF PRIDE OURSELVES ON ENSURING LOW COST TREATMENTS AND THAT ALL OF OUR PATIENTS ARE SEEN ON TIME, WITHOUT ANY UNNECESSARY WAIT TIMES TYPICALLY EXPERIENCED WITH OTHER SERVICE FACILITIES.

TO ACCOMPLISH THIS, WE RELY UPON OUR PATIENTS COMMITMENT TO KEEPING APPOINTMENTS THEY HAVE SCHEDULED FOR THEIR CONVENIENCE.

THEREFORE, PLEASE NOTIFY US 24 HOURS IN ADVANCE IF YOU CANNOT KEEP YOUR APPOINTMENT SO WE HAVE THE OPPORTUNITY TO SCHEDULE ANOTHER PATIENT WITHIN YOUR APPOINTMENT TIME.

ANY APPOINTMENTS MISSED OR CANCELLED THE DAY OF THE PROCEDURE WILL AUTOMATICALLY ASSESS A $50.00 FEE TO PARTIALLY COVER THE COST OF THE TECHNICIAN ASSIGNED TO YOUR APPOINTMENT. AN INVOICE WILL BE SENT TO YOUR EMAIL WITH THE PENALTY FEE. PLEASE BE ADVISED YOU CANNOT BOOK OR BE SEEN UNTIL THE $50.00 FEE IS PAID IN FULL.

PATIENT: ____

DATE: ____