Seguin Family Medicine & Medispa
with Dr. Nicole Talbot

LipoMelt Intake Form

(Please Print Clearly)

Your Name:	Referred by:	Today's Date:
Address:	City: State:	Zip:
Home #:	Work #:	Cell #:
Email Address:		
Height: Weight:	Date of Birth: Age:	Sex:
Marital Status:	Are you pregnant? ❑ No ❑ Yes, how far along?	
How much water do you consume per day?		
Occupation:	How many hours per week do you work?	
Are you currently under the care of a physician? ❑ No ❑ Yes, for what reason(s):		
How stressed are you? (On a scale of 1 to 10, where 10 is the worst):		
Have you ever had any health conditions that affected your liver? ❑ No ❑ Yes, explain:		
Have you ever had cancer? ❑ No ❑ Yes, explain:		
Do you exercise? ❑ No	❑ Yes, how often?	What type?
Which do you want us to focus on? ❑ Abdomen ❑ Buttocks ❑ Thighs ❑ Chest ❑ Arms ❑ Neck ❑ Cellulite		

How long have you been overweight?
How much weight do you want to lose?
Are you embarrassed about your weight/appearance? ❑ No ❑ Yes, explain:
How important is weight or size reduction to you? (On a scale of 1 to 10, where 10 is the most important)
Are other members of your family overweight? ❑ No ❑ Yes
Do you feel tired, run down, or out of energy? ❑ No ❑ Yes, explain:

I clearly understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment.

Your Name (print): _____

Signature: _____ Date: _____

---------- DO NOT WRITE BELOW THIS POINT ----------

Provider's Notes:

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LipoMelt.....Melt That Fat Away

Informed Consent and Release of Liability Form

Name: (First)_____ (Last)_____DOB_____

Program and Background
You have requested treatment utilizing LipoMelt LED light therapy. This treatment is the application of a 635nm and 880nm light, which causes fat within the adipose (fat) cell to leave and accumulate in the interstitial space. This excess fat is removed by the body's lymphatic system and excreted without negative side effects or downtime. Any medical or cosmetic procedure carries risks, complications and varied results. The purpose of this document is to inform of the nature of this product and it's risk. LED therapies have been approved by the FDA.

Procedure
Initially you will consult with a LipoMelt therapist to determine if you are a candidate for the LED therapy. You will have the opportunity to ask questions or voice concerns you may have regarding this treatment. If it is determined you are a candidate for this procedure, then paperwork, measurements, pre and post treatment photos (upon your approval) and suggested course of treatment will be given. The treatment is administered by placing up to 6 LED pads on the desired area(s) to be treated. Most patients will need a minimum of 9 – 12 treatments for the Light LED therapy to achieve its desired effect. This treatment should be used in conjunction with a healthy diet and exercise. You should consult a health care professional before beginning any new exercise program to determine if your body is physically able.

Risks/Discomfort
This treatment is non-invasive. During treatment there should be no discomfort. The client may feel the warmth of the light. LipoMelt is suitable for anyone over 18 who does not have any of the following issues:

Pregnancy, Breast Feeding, Recent Cancer, Heart Disease, Pacemaker or Metal Pins or Plates.

Benefits
LED light therapy has become more prominent and has been used in many studies for pain management and recently by cosmetic surgeons to emulsify adipose before liposuction with FDA approval. The potential benefit of this treatment is body contouring without surgery. Problem areas or excess pockets of fat can be targeted, however the most commonly treated areas are the stomach, hips, flanks, and thighs. In clinical trials patients have averaged 2-5cm lost from their stomach, hips, and thighs. These results vary and no guarantee is implied or suggested that desired results will be achieved.

Voluntary Cosmetic Procedure

_____(Initial) I understand that this is a strictly voluntary cosmetic procedure. No treatment is necessary or required and the LipoMelt LED therapy has been chosen by myself (the client).

_____(Initial) I have been informed of the potential risks and side effects of LipoMelt including but not limited to redness, swelling, heat sensitivity, pain, increase bowel movements and increased urination. The risks, potential damages and adverse side effects have been explained to me and I fully understand them.

_____(Initial) I understand that a minimum of 9 - 12 treatments is required to achieve results at an average BMI of 25 to 30. A BMI of over 30 (which is considered in the obese range) requires a specific strategy moving forward with the minimum recommendation of 24 + treatments. Each body is different and may require more or less treatments depending on the client's diet, exercise, metabolism and body type. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program.

_____(Initial) I know that if after the treatment program I gain weight, the results of the LipoMelt may be reversed.

_____(Initial) I understand that no guarantee has been given as to the results that may be obtained by this treatment. I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information and feel I am sufficiently advised to consent to this procedure. I herby give my consent to have this procedure. If at any time during the LipoMelt procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/ or terminate the session at my discretion.

Melt That Fat Away

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_____(Initial) I duly authorize technicians to perform the procedure for the purpose of body contouring, lymphatic drainage, improvement of cellulite and skin tightening. I am aware that clinical results may vary depending on individual factors, medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. If I do not make an effort to address my diet and exercise, the results achieved may not be retained.

_____(Initial) I have reviewed this consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form I grant authority to perform the described treatment. The purpose of this procedure, risks, complications, alternative methods of treatment have been fully explained to my satisfaction. Cosmetic indications for these procedures include but are not limited to cellulite reduction, treatment of problem fat areas, skin tightening, and skin rejuvenation. Increased redness to the area for up to 12 hours may be experienced (although this is unlikely). Normal activities may be resumed following the treatment. Any photos taken will be used to show the clients progress and may be used in marketing ads.

Questions and Explanations
By signing below, you certify that this procedure has been explained to you and that you have been fully informed of the nature and purpose of the LipoMelt procedure, expected outcomes and possible complications, and understand that no guarantee can be given as to the final results obtained. You are fully aware that your condition is of a cosmetic concern and that the decision to proceed is solely based upon your expressed desire to do so. You are aware that LipoMelt may/can cause slight hypo/hyper–pigmentation of the skin and treatment is taken at your own risk (tattoo areas should be avoided). Any further questions can be directed to a LipoMelt Specialist. Furthermore you are of lawful age and legally competent to sign this aforementioned release, and that you understand the terms herein is contractual and not a mere recital; You have signed this document of your own free will.

Whole Body Vibration Plate Exercise Risks
Whole Body Vibration Plate Machines are scientifically calibrated exercise machines designed to force your muscles to stretch and contract rapidly in small increments, replicating the same action which occurs during traditional exercising. Vibration exercises use your body weight and gravity to it's fullest potential. Please do not use a whole body vibration plate or any other exercise device without getting approval from your doctor.

The device is not recommended if you are: pregnant, diabetic with complications such as neuropathy or retinal damage, have a pacemaker, recently underwent surgery, suffer from Epilepsy or Migraines, have herniated disks, spondylolisthesis, spondylolysis , have cancer or tumors, have recent joint replacements, have metal pins or plates, or have any other concerns about your physical health. These contra-indications do not mean that you are not able to use a vibration or other exercise device, but it is recommended that you consult your physician first.

_____(Initial) I understand that using a whole body vibration machine workout is a strictly voluntary physical activity chosen by myself (the client). If at any time I experience pain or discomfort of any kind, I agree to inform the staff immediately and/or terminate the exercise.

OUR PRIVACY POLICY

We value your privacy, and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. We do not disclose identifiable information to any third party without your consent. Further, we do not sell, rent, or otherwise allow the unauthorized outside use of personal information such as names, addresses, phone numbers, or e-mail addresses in our database without your permission. Copies of this form and signature will be valid as if original if this document is digitally scanned. If any part of this Release is found to be invalid by the courts having jurisdiction, or becomes inoperative for any reason, such invalidity shall not affect the validity and enforceability of any other provision of this release.

POLICIES AND TERMS AGREEMENTS

Cancellation Policy
We require a 24 hour cancellation notice.
* If I cancel within 24 hours of a reserved session, I will lose or forfeit my session
* If I cancel within 24 hours of a reserved session, I might incur a $35 no-show fee

If I fail to show up or am more than 5 minutes late, I will lose or forfeit my session due to staff wages and fees paid for my session. Our cancellation policy has been created to ensure that our loyal clients are not disturbed by the tardiness of clients who do not show up on time, or who cancel within 24 hours of an appointment. When reserved sessions are unattended, this means that loyal clients missed the opportunity of having that particular time period.

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Purchase and Reservation Policy
Sessions will only be confirmed and allowed up to the amount of pre-paid sessions. All sales are final and non-refundable. We reserve the right to terminate any client's session, package, or contract, without refunding any monies if the client has broken any terms or policies. All purchases are final, non-refundable and non-transferable.

* I understand if I have purchased and pre-paid for a first-time customer promotion, that I may not use or purchase another first-time promotion without consent. I further state that I am of lawful age and legally competent to sign this aforementioned release. The procedures, alternatives and risks have been explained to me and I have been given the opportunity to ask questions. I understand it is my responsibility to inform the staff is there are any changes to my medical history. I understand the terms herein is contractual and not a mere recital. I have signed this document of my own free act.

I HAVE CAREFULLY READ, UNDERSTOOD AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS.

Client's Name	Client's Signature	Date
Staff Member's Name	Staff Member's Signature	Date

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Patient Photograph Release Form for LipoMelt

Patient Information:

Patient's Name _____ Patient's Date of Birth _____

I hereby authorize Seguin Family Medicine (the "Company") to use and disclose photographs, films, illustrations or videotapes (the Photos) and all aesthetic treatment-related information, taken or collected by my health care provider (the "HCP") in conjunction with my aesthetic treatment(s) on or about _____, 20_____, all of which include information considered "protected health information" ("PHI") under the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I authorize the Company, in its sole discretion, to use and disclose the Photos and aesthetic Information on its corporate and product websites, in printed brochures, news releases, videos, television and other media marketing materials for any bona fide business purpose, including, but not limited to, dissemination to employees, clients, health professionals and members of the general public for educational, research, scientific, public relations, marketing, or advertising in any form of media, and that such dissemination may be accomplished in any manner deemed appropriate by the Company. Such purposes may include showing actual patient results through the use of "before" and "after" photographs. I understand that once so used and disclosed, the Company has no control or responsibility over how my Photos will be used or further disclosed. Neither I, nor any member of my family, will be identified by name in connection with the Photos or aesthetic Information at any time.
If I have any questions regarding this Authorization, I should call Trish Blass at 830-372-5204.

I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must send written notification to Seguin Family Medicine, 515 N. King Street, Suite 103, Seguin, TX 78155.

Please initial **ONE** of the following options:

_____ Yes, I agree to the terms of the Authorization above.

_____ No, I authorize my photographs to be used only for my medical record, my treatment record and insurance purposes of my treatment with Seguin Family Medicine. I understand these photos will not be used on the office website or in any publications.

Signature: _____ Date: _____

Print Name: _____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE PROVIDED TO THE PATIENT