Shima Lipolaser

Client Information

Name: _____ Last name: _____ Date: _____

Date of Birth (mm/dd/yy): _____ Sex: male female

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Phone #: (C) _____ (H) _____ (W) _____

E-mail address (Please print): _____

Purpose of visit: _____ Date of injury: _____

Other therapies you are currently receiving: _____

- 24 hour cancellation notice is required otherwise there will be a $40 no show fee.
- Package pricing is non-refundable/non-transferable/one year expiration.

The Shima LipoLaser is a new and innovative technology that has been approved spot fat reduction and body contouring in Canada and Europe. In the U.S., the Shima LipoLaser is presently approved for pain management, and doctors are using the device as off-label application for spot fat reduction and body contouring.

The Shima LipoLaser is one of the tools that we can use to help you reach your goals and the real advantage of this technology lies in the fact that we can specifically target a trouble area. Once the fats have been released from the cell they can be used by the body as a fuel source. It is therefore critical that the dietary and lifestyle changes are made to help support the goals of treatment.

A reduced calorie diet and an exercise program that will help to burn approximately 350 – 500 calories post treatment are ideal. Individual results may vary and it is the responsibility of the client to ensure they are doing the appropriate home care to ensure maximum results. Clients should be consuming a caloric intake equivalent to their target weight (lbs) multiplied by 10. For example a 220lb male who wants to reach 200 lbs should be consuming a daily intake of 2000 calories. In some cases additional support may be required for lymphatic drainage to help stimulate the body to clear the fats that are released from the cell. Most clients experience a ½ inch reduction with each treatment and multiple inches can be lost with a series of treatments.

I confirm the following:

_____ I am over the age of 18
_____ I am not pregnant or lactating
_____ I do not have epilepsy
_____ I do not have a pacemaker
_____ I do not have Herpes Simplex
_____ I do not have uncontrolled Hypertension
_____ I have no known liver or kidney disorders
_____ I have no known thyroid gland dysfunctions
_____ I do not have a compromised immune system
_____ I do not have cancer or a history of cancer
_____ I have no known photosensitivity to sun exposure
_____ I am not taking drugs that cause photosensitivity

I consent to taking photographs for progress charting _____ (*initials*). Photos will remain at Orlando Spinal Aid at all times.

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Shima Lipolaser

Limitation to Treatment:

_____ I understand there are no guarantees as to the results of this treatment
_____ I understand that to achieve maximum results, I may require several treatments
_____ To achieve optimum results, I understand that an appropriate diet and regular exercise will assist to sustain and create accumulative degree of overall spot fat reduction and body contouring

Risk:

I have been informed and I understand the temporary hyperpigmentation / hypopigmentation on rare occasion may occur as a result of treatment. I hereby certify that all information that I have provided has been accurate and truthful.

I hereby authorize Orlando Spinal Aid Center to perform the Shima LipoLaser procedure for the purpose of aesthetic body contouring and girth ___(*initials*).

Patient Agreement

I, _____, in signing this agreement understand that I am beginning a series of treatments to help reach my goals of body contouring and spot fat reduction. I understand that individual results may vary and that I must commit to changing the dietary and lifestyle factors necessary to achieve optimal results. I understand that the first step to a positive change is creating awareness about the steps necessary to reach these goals, and will work diligently to ensure success.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I realize there may be pre-existing medical conditions that can preclude me from seeing optimal results. By signing this agreement I release the spa/clinic, manufacturer and distributors from any liability regarding this treatment and do so understanding that results can vary from one individual to the next.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions what so ever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Client: _____ Date: _____

Witness: _____

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PATIENT CONSENT FOR TREATMENT

This is an important decision towards improving your wellness and overall lifestyle! We share the mutual desire of you reaching all of your wellness goals involving the Shima LipoLaser. In order for you to reach these goals, we have provided a few points to educate you on achieving your best results. It is important to manage your expectations according to an appropriate diet, lifestyle and exercise program incorporated in conjunction with your Lipolaser treatment protocol.

Ensure Your Best Results

- Avoid consuming large amounts of water prior to treatment(s)
- Don't eat 2 to 4 hours prior to treatment(s)
- Drink plenty of water after every treatment
- Incorporate Whole Body Vibration (WBV) post treatment for 10 minutes or ensure you undertake physical activity following each treatment to maximize your results
- Manage caloric intake; excess calories will counteract the laser treatments
- Alcoholic beverages and high sugar content drinks must be avoided before and after treatment(s)

My signature herein constitutes my acknowledgment that I am a competent, consenting adult of at least 18 years of age (or my parent or legal guardian is giving consent on my behalf), and further, that I:

- Have read and understand the information provided in this form;
- Have had my procedure adequately explained to me by my clinician/Doctor;
- Have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction;
- Have received all of the information I desire concerning my procedure;
- Understand all post treatment recommendations and agree to adhere to them;
- Freely assume any risks of complications or injury from known or unknown causes associated with, relating to, or otherwise arising out of this procedure;
- Have the right to consent to or refuse any proposed procedure at any time prior to its performance;
- Must notify the clinician if my medical history changes prior to subsequent treatments;
- Consent to photographs of the treatment area;

I _____consent to, and authorize Orlando Spinal Aid Center to perform the laser treatment for the area of_____.

Signature: _____ Date: _____

Printed Name: _____

100% certainty of success cannot be assured as with any medical procedure. It is also important to note that in the vast majority of cases, supported by clinical studies, patients achieve results. Results may vary and therefore not meet expectations of all patients completing a full series of treatments.

Orlando Spinal Aid Center....11333 Lake Underhill Road. Suite. 105 Orlando, FL 32825 (407) 277-5555

info@lipolaserenvy.com Http://www.shimalipolaser.com

SHIMA Laser Lipo Consent and Release Form

Name: (First) _____(Last) _____DOB _____

A. Program and Background

You have requested to be treated with the Shima low-level laser therapy provided by Orlando Spinal Aid Center. This treatment is the application of a 635nm low intensity laser, which has been shown through extensive research to cause the fat within the adipocyte (fat cell) to leave the cell and accumulate in the interstitial space around the cells. In contrast to high- power, high heat lasers that are used in various medical procedures, the low level laser used for this treatment has no thermal effect on tissue. Instead, the non-invasive laser helps the body absorb fat by stimulating its biological function. Excess fat is then removed naturally by the body's lymphatic system and subsequently excreted without the negative side effects and downtime associated with more invasive procedures such as liposuction.
This therapy has been tested in several institutional review board approved studies in a double blind; placebo controlled fashion and found to be generally effective. Any medical or cosmetic procedure carries risk, complications and varied results as to the effectiveness of a particular treatment. The purpose of this document is to make you aware of the nature of this product and its risks in advanced so that you can decide whether to go forward with this procedure.

Non-invasive low level laser therapy has been approved by the FDA.

B. Procedure

Initially you will consult with the doctor to determine if you are a candidate for low level laser therapy. During this time period you will have the opportunity to ask questions or voice concerns you may have concerning this treatment. If it is determined you are a candidate for this procedure, there will be a few preliminary steps consisting of: paperwork, and measurements. Proceeding, the patient will need to expose the area to be treated and lie down. From here the treatment will be administered by placing 2-4 635nm low level laser paddles on the desired area(s) to be treated.

It is recommended that a patient will need a minimum of six treatments for the low level laser to achieve its potential effect. This treatment should be used in conjunction with a healthy diet and exercise. If you are not currently exercising you should consult a health care professional before beginning an exercise program to determine if your body is physically able.

C. Risks/Discomfort

There are few risks associated with low level laser therapy. This treatment is non-invasive and uses a cold output laser.

During treatment no discomfort will be present, the patient will not feel the laser, however the light will be visible.

*Please inform us if you think you are pregnant, or are unsure if you may be pregnant, as a pregnancy test may be required to proceed with treatment. Although no known detrimental risks exist, potential unknown risks may exist. If you have a pacemaker, this treatment may not be right for you. It is recommended that one does not treat directly over a pacemaker or its lead wires. No known risks exist, however potential unknown risks may exist. There are also a variety of other conditions for this treatment. It is possible that you may not see any improvement in your body shape or it may get worse.

There also may be unknown risks associated with low-level laser therapy.

D. Benefits

Over the years the benefits of low-level laser therapy have become more prominent. Low-level laser therapy has been used by chiropractors 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 4.5 inches lost from there stomach, hips, and thighs. These results do vary and no guarantee is implied or suggested that desired results will be achieved.

E. Alternatives

This is strictly voluntary cosmetic procedure. No treatment is necessary or required. Alternative treatments, which vary in sensitivity, effect, duration, and invasiveness include: liposuction, mesotherapy, lipodissolve, velasmooth, dieting, exercise and potential others; which may have their own risks and benefits. You acknowledge this, and realize that the other option to you is do nothing.

F. Questions

By signing below, you certify that this procedure has been explained to you and your satisfaction. Any further questions can be directed to Orlando Spinal Aid Center.

G. Consent

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 for Orlando Spinal Aid Center to perform the described treatment or administer any related treatment as deemed necessary or advisable for my medical condition. 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. You may experience increased redness to the area for up to 12 hours. You will be able to return to most normal activities following the treatment.

I have been informed of the potential risks and side effects of Laser Lipo including but not limited to redness, swelling, heat sensitivity, pain, increase bowel movements, increased urination, increased menstrual flow and flu like symptoms, the nature of the proposed procedure. The risks, potential damages and adverse side effects have been explained to me and I fully understand.

_____Initial

I understand that a minimum of 6 treatments is required to achieve full results. At that point I will be re-evaluated to see if more sessions are needed in order to achieve realistic goals. Patients who are extremely thin may require fewer treatments, while heavier patients may require more. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program. I know that if after the treatment course I gain weight, the results of the Laser Lipo may be reversed.

_____Initial

No guarantee has been given by anyone 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 Laser Lipo procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/ or terminate the session at my discretion.

The undersigned assumes all responsibility for behavior of self and their clients and agrees to abide by all Rules and Procedures of the property.

Clients are responsible for the completion and timely return of any client forms and payments, including but not limited to new client intake forms.

The clients and all persons on the premises by invitation of the clients herby hold Orlando Spinal Aid, its employees, the corporation or any individual connected in any way to ORLANDO SPINAL AID CENTER, harmless for any responsibility or liability for any accident, injury illness or damages sustained by or to any person or their personal property during their treatment appointments or use of facilities. ORLANDO SPINAL AID CENTER shall be indemnified and held harmless by the clients,

and clients agree to pay all costs incurred in connection with any accident, injury illness or property damage loss, including attorney's fees, regardless of how it may have occurred.

The undersigned hereby releases and indemnifies ORLANDO SPINAL AID CENTER and holds harmless any employee, the corporation or any individual connected in any way to ORLANDO SPINAL AID CENTER for any loss of personal property and/ or accident causing personal injury of any nature, including reasonable attorney's fees and court costs in connection therewith.

However, in the event of an occurrence, the client should inform our team members who will do everything within reason to rectify the problem.

All information regarding the procedure is checked to ensure the accuracy of descriptions. However, we are not always able to control all of the components of the facility, city power outages, etc., and it is possible that an appointment time or procedure may become unavailable due to circumstances beyond our control and for which we do not accept liability.

I further state that I am of lawful age and legally competent to sign this aforementioned release; I understand the terms herein is contractual and not a mere recital; I have signed this document of my own free act.

At ORLANDO SPINAL AID CENTER we place the highest priority on the client's right to privacy. We recognize the added sensitivities for client's receiving body sculpting therapy. Our office staff is trained to protect our private health information, and our waiting areas are intentionally shielded and discrete.

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.

REFUND POLICY

If you purchase additional Laser Lipo treatment(s) and do not wish to use your purchase, we will gladly give you a refund of your purchase price minus a processing fee of $35.00.

PHYSICIAN and or LASER TECH ESTHETICIAN

I have explained the procedure, alternatives, and risks to the person or persons whose signature is affixed below. The patient has verbally communicated to me that they understand the contents of this form.

_____ _____

Signature of Physician/LASER TECH ESTHETICIAN Date

PATIENT CERTIFICATION

By signing below I state that I am 18 years of age or older, or otherwise have authorized to Consent the above

information. I have read or have had explained to me the contents of this form. I understand that information on this form and give my consent to what has been explained to me.

I authorize ORLANDO SPINAL AID CENTER to perform my treatment:

Print Name: _____

Signature:_____ Date:_____