

# COLORADO BODY SCULPTING & REJUVENATION CENTER

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PATIENT NAME

## PATIENT GOAL ASSESSMENT FORM

What is most important to you when choosing services to help you meet your cosmetic goals?

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Why are these goals important to you?

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How will you know when you have found the medical practice that will best fit your needs?

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Target date for achieving your personal improvement goals: \_\_\_\_\_

Rate your level of commitment to achieving your personal improvement goals – (scale of 1 to 10 with 10 being the highest): \_\_\_\_\_

**Areas of Desired Improvement:**

**Face/Neck**

Specific Appearance Goal: \_\_\_\_\_

**Breast** – Desired cup size: \_\_\_\_\_

Specific Appearance Goal: \_\_\_\_\_

**Abdomen/Waist** – Desired reduction in inches: \_\_\_\_\_

Specific Appearance Goal: \_\_\_\_\_

**Thighs/Upper Legs** – Desired reduction in inches: \_\_\_\_\_

Specific Appearance Goal: \_\_\_\_\_

**Hips/Buttocks** – Desired reduction in inches: \_\_\_\_\_

Specific Appearance Goal: \_\_\_\_\_

**Back** – Desired reduction in inches: \_\_\_\_\_

Specific Appearance Goal: \_\_\_\_\_

**Calves/Lower Legs** – Desired reduction in inches: \_\_\_\_\_

Specific Appearance Goal: \_\_\_\_\_

**Upper Arms** – Desired reduction in inches: \_\_\_\_\_

Specific Appearance Goal: \_\_\_\_\_

**Specific Interest Goals:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

## AESTHETIC PATIENT PROFILE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Reason for your visit:

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How would you describe your skin type?

- \_\_\_\_\_ Normal
- \_\_\_\_\_ Oily
- \_\_\_\_\_ Combination
- \_\_\_\_\_ Dry

With sun exposure, does your skin?

- \_\_\_\_\_ Always burns/never tans
- \_\_\_\_\_ Sometimes burns/sometimes tans
- \_\_\_\_\_ Seldom burns/usually tans
- \_\_\_\_\_ Almost never burns/always tans

Are you currently using acne, bleaching or any other topical creams? \_\_\_\_\_

If yes what kind of cream? \_\_\_\_\_

When was the last time you used it? \_\_\_\_\_

Have you had any recent injections? \_\_\_\_\_ What kind and where? \_\_\_\_\_

If applicable, what is the date of your last injection? \_\_\_\_\_

Do you currently have, or have you had any of the following skin conditions:

- |                                    |                               |
|------------------------------------|-------------------------------|
| _____ Acne                         | _____ Rosacea                 |
| _____ Sun induced eruption (Lupus) | _____ Eczema                  |
| _____ Abnormal Nevi (Moles)        | _____ Allergic contact rashes |
| _____ Skin cancers or pre-cancers  | _____ Other: _____            |

# PRESENT MEDICAL HISTORY

Do any of the following medical conditions apply to you? (Check all that apply)

- Pregnancy
- Epilepsy
- Cardiac or vascular disease/condition
- Acute inflammation
- Unhealed wounds
- History of internal bleeding
- Pacemaker or other electronic devices
- Plastic, bone cement or metal Implants
- Recent abdominal surgery
- Abnormal high or low blood pressure
- Do you get out of breath easily?
- Do you sometimes get out of breath when sitting still or sleeping?
- Has a doctor ever told you your cholesterol level was high?
- Communicable diseases
- Melanoma
- Thrombosis or thrombophlebitis
- Transplants
- Taking any anti-coagulants
- Keloids
- Heart trouble
- Current Infection
- Any infections diseases or tuberculosis
- Diabetes
- Kidney or liver disease

PLEASE LIST ANY MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

ARE YOU ALLERGIC TO ANY FOODS OR MEDICATIONS? \_\_\_\_\_

EXPLAIN ANY OTHER CURRENT MEDICAL CONDITIONS:

\_\_\_\_\_

\_\_\_\_\_

FOR FEMALES: ARE YOU PREGNANT OR NURSING? \_\_\_\_\_

ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE? IF SO, WHAT FOR?

\_\_\_\_\_

\_\_\_\_\_

**FEES: ALL COSTS ARE TO BE PAID IN FULL PRIOR TO INITIAL TREATMENT AND ARE NON-REFUNDABLE. COSTS DO NOT INCLUDE FUTURE VISITS, UNLESS OTHERWISE EXPRESSED. CLIENT MUST PAY FOR ANY SPECIAL OFFERS ON SECOND VISIT TO RECEIVE PACKAGE DISCOUNT. DISCOUNTED PACKAGES ARE NON-REFUNDABLE.**

**TREATMENT DISCLOSURE:** THE 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 COLORADO BODY SCULPTING & REJUVENATION CENTER DOES NOT GUARANTEE ANY SPECIFIC RESULT.

**AFTERCARE:** PATIENTS ARE REQUIRED TO DRINK AT LEAST 1.5 LITERS OF WATER ON A DAILY BASIS WHEN UNDERGOING THIS PROCEDURE. ALSO, BE PREPARED TO COMPLETE A 30-45 MINUTE CARDIO WORKOUT. 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 PICTURE:** BEFORE, DURING OR AFTER PICTURES MAY BE TAKEN TO DOCUMENT YOUR TREATMENT. THESE PICTURES BECOME COLORADO BODY SCULPTING & REJUVENATION CENTER'S SOLE PROPERTY AND ARE ONLY USED FOR ITS LEGITIMATE RECORD KEEPING.

**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 COLORADO BODY SCULPTING & REJUVENATION CENTER (INCLUDING ITS OFFICERS, MEMBERS, OWNERS, EMPLOYEES AND AGENTS) FROM ANY AND ALL DAMAGES, COSTS, EXPENSES, LIABILITIES, CAUSE OF ACTION, CLAIMS AND DEMANDS OF WHATEVER CHARACTER IN LAW OR EQUITY, WHETHER KNOWN OR UNKNOWN, DIRECT OR INDIRECT, ASSERTED OR UNASSERTED AND WHETHER OR NOT IN ACCOUNT OF MYSELF OR COLORADO BODY SCULPTING & REJUVENATION CENTER OR OTHER THIRD PARTIES WHOSE CLAIMS MAY ARISE OUT OF, OR RELATE TO, THE TREATMENT I HAVE REQUESTED COLORADO BODY SCULPTING & REJUVENATION CENTER 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 COLORADO BODY SCULPTING & REJUVENATION CENTER, 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 SHALL BE RESOLVED UNDER STATE OF COLORADO 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.

**IDEMNIFICATION:** I AGREE TO INDEMNIFY, HOLD HARMLESS AND DEFEND COLORADO BODY SCULPTING & REJUVENATION CENTER (INCLUDING ITS OFFICERS, MEMBERS, OWNERS, EMPLOYEES AND AGENTS) AGAINST ALL THIRD PARTY CLAIMS, CAUSES OF ACTION, DAMAGES, JUDGEMENTS, COSTS OR EXPENSES, INCLUDING ATTORNEY'S FEES AND ANY OTHER LITIGATION COSTS, WHICH MAY IN ANY WAY ARISE FROM THE ABOVE DESCRIBED TREATMENT I HAVE REQUESTED COLORADO BODY SCULPTING & REJUVENATION CENTER TO PERFORM.

**ARBITRATION:** IT IS UNDERSTOOD THAT ANY DISPUTE ARISING AS TO MALPRACTICE OF THE THERMA-LIFT/ULTRA LIFT TREATMENT SHALL BE DECIDED BY A NEUTRAL ARBITRATOR. ANY ARBITRATION WILL BE GOVERNED BY STATE OF COLORADO ARBITRATION STATUTES. THE FEES FOR THE ARBITRATOR WILL BE SPLIT PRO-RATA AMONG THE PARTIES AND EACH PARTY WILL BE RESPONSIBLE FOR THEIR OWN ATTORNEY'S FEES AND COSTS. ANY ACTION TO COLLECT FEES FROM THE CLIENT/PATIENT FOR THE TREATMENTS PERFORMED MAY BE BROUGHT IN ANY COURT LOCATED IN STATE OF COLORADO AND PREVAILING PART. IN SUCH COLLECTION, ACTIONS SHALL BE ENTITLED TO RECOVER ANY REASONABLE ATTORNEY'S FEES AND COSTS. FILING OF ANY ACTION IN ANY COURT TO COLLECT ANY FEE FROM CLIENT/PATIENT SHALL NOT WAIVE THE RIGHT TO COMPLETE ARBITRATION OF ANY MALPRACTICE CLAIM.

**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 PROCEDURE'S RISKS AND HEREBY CONSENT TO THE INIDICATED PROCEDURES. THIS MEANS THAT 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. ACCORDING TO THIS AGREEMENT, I HEREBY AGREE TO ARBITRATION OF ANY MALPRACTICE CLAIM. 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: \_\_\_\_\_

**COLORADO BODY SCULPTING & REJUVENATION CENTER**

(ACCEPTED BY TECHNICIAN): \_\_\_\_\_ DATE: \_\_\_\_\_

## THERMA-LIFT CONSENT FORM

PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

**PURPOSE/PROCEDURE:** THERMA-LIFT IS THE CONTROLLED RADIO-FREQUENCY HEALING OF DEEP SKIN WITH COOLING OF THE SURFACE SKIN. RADIO-FREQUENCY IS A RECENT AND NEW TECHNOLOGY WHICH HEATS THE UNDERLYING TISSUES IN THE SKIN, PROMOTING NEW COLLAGEN FORMATION.

**RISKS:** JUST AS THERE MAY BE BENEFITS TO THE PROCEDURE PROPOSED, I UNDERSTAND THAT ALL PROCEDURES INVOLVE RISKS TO SOME DEGREE.

**DISCOMFORT:** THIS TREATMENT USES HIGH HEAT. SOME PEOPLE MAY FEEL PAIN WITH THIS TREATMENT. THE DISCOMFORT IS USUALLY TEMPORARY, LASTING ONLY A FEW SECONDS.

**REDDENING:** TREATMENT MAY CAUSE A REDDENING OF THE AREA. THE REDDENING WILL USUALLY GO AWAY IN 1 TO 2 HOURS FOLLOWING TREATMENT. IN SOME INSTANCES, THE REDNESS CAN PERSIST FOR SEVERAL DAYS.

**SWELLING:** TREATMENT MAY CAUSE SWELLING, WHICH WILL USUALLY GO AWAY IN 3 TO 5 DAYS OR LESS.

**BRUISING:** TREATMENT MAY CAUSE BRUISING, BUT THIS IS EXTREMELY UNCOMMON.

**ALTERED SENSATION:** THERE MAY BE ALTERED SENSATION, OR PERMANENT OR TRANSIENT NERVE DAMAMGE AT THE TREATMENT SITE. HOWEVER, THIS IS EXTREMELY UNLIKELY BECAUSE THE SYSTEM HAS BEEN DESIGNED TO DELIVER A CONTROLLED APPLICATION OF ENERGY TO THE TISSUE.

**PIGMENT CHANGES:** THE TREATED AREA MAY HEAL WITH INCREASED OR DECREASED PIGMENTATION. THIS OCCURS MOST OFTEN WITH DARKER PIGMENTED SKIN AND AFTER EXPOSURE OF THE AREAS TO THE SUN. YOU MAY HAVE EXPERIENCED THIS TYPE OF REACTION BEFORE WITH MINOR CUTS OR ABRASIONS. THE TREATED AREA MUST BE PROTECTED FROM EXPOSURE TO THE SUN (WE RECOMMEND COVERING THE AREA WITH SUNSCREEN FOR 2-3 WEEKS FOLLOWING TREATMENT).

**RESTRICTIONS:** I UNDERSTAND THAT IF I'VE HAD DERMA FILLER WITHIN THE PAST 2 MONTHS OR NEUROTOXIN (BOTOX, DYSPORT, JUVEDERM) WITHIN THE PAST 2 WEEKS, IT IS POSSIBLE THAT THE HEAT FROM THE THERMA-LIFT CAN BREAK DOWN AND DIMINISH THE EFFECTIVENESS OF THE DERMA FILLER OR NEUROTOXIN. I ALSO UNDERSTAND THAT

FOLLOWING MY THERMA-LIFT TREATMENT, IT IS BEST TO AVOID DERMA FILLER FOR 2 MONTHS AND NEUROTOXIN FOR 2 WEEKS.

**BENEFITS:** TIGHTENS AND LIFTS SAGGING SKIN. OVER TIME, NEW COLLAGEN IS PRODUCED TO FURTHER TIGHTEN THE SKIN, RESULTING IN HEALTHIER, SMOOTHER SKIN AND A MORE YOUTHFUL APPEARANCE.

**CONSENT:** YOU HAVE READ THIS FORM AND UNDERSTAND IT. YOU REQUEST THE PERFORMANCE OF THE PROCEDURE DESCRIBED ABOVE. YOU HAVE BEEN GIVEN A COPY OF THIS CONSENT FORM UPON REQUEST. YOUR CONSENT AND AUTHORIZATION FOR THIS PROCEDURE IS STRICTLY VOLUNTARY. BY SIGNING THIS INFORMED CONSENT FORM, YOU HEREBY GRANT AUTHORITY TO PERFORM THERMA-LIFT.

THE NATURE AND PURPOSE OF THIS PROCEDURE, WITH POSSIBLE COMPLICATIONS, HAVE BEEN FULLY EXPLAINED TO YOUR SATISFICATION. NO GUARANTEE HAS BEEN GIVEN BY ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED BY THIS TREATMENT.

I AGREE TO HAVE PHOTOGRAPHS TAKEN FOR DOCUMENTATION, AS WELL AS INTERNAL OFFICE USE.

I HAVE READ THIS CONSENT AND CERTIFY THAT I UNDERSTAND ITS CONTENTS IN FULL. I HAVE HAD ENOUGH TIME TO CONSIDER THE INFORMATION AND FEEL THAT I AM SUFFICIENTLY ADVISED TO CONSENT TO THIS PROCEDURE. I HEREBY GIVE MY CONSENT TO THIS PROCEDURE AND HAVE BEEN ASKED TO SIGN THIS FORM AFTER MY DISCUSSION WITH COLORADO BODY SCULPTING & REJUVENATION CENTER.

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**PATIENT SIGNATURE**

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**DATE**



# ULTRA LIFT CONSENT FORM

**PATIENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PURPOSE/PROCEDURE:** ULTRA LIFT IS A NON-SURGICAL TREATMENT THAT LIFTS AND STIMULATES THE MUSCLE. IT HAS BEEN EXPLAINED TO ME THAT RESULTS VARY FROM PATIENT TO PATIENT. I UNDERSTAND THAT THE RESULTS WILL UNFOLD OVER A COURSE OF 2 TO 3 MONTHS AND THAT SOME PATIENTS MAY BENEFIT FROM MORE THAN ONE TREATMENT. ULTRA LIFT MAY ALSO BE USED AS A MAINTENANCE TREATMENT.

**RISKS:** JUST AS THERE MAY BE BENEFITS TO THE PROCEDURES PROPOSED, I UNDERSTAND THAT ALL PROCEDURES INVOLVE RISKS TO SOME DEGREE.

**DISCOMFORT:** SOME PEOPLE MAY FEEL SOME PAIN WITH THIS TREATMENT. THE DISCOMFORT IS USUALLY TEMPORARY, LASTING ONLY A FEW SECONDS.

**REDDENING:** TREATMENT MAY CAUSE A REDDENING OF THE AREA. THE REDDENING WILL USUALLY GO AWAY IN 1 TO 2 HOURS FOLLOWING TREATMENT. IN SOME INSTANCES, THE REDNESS CAN PERSIST FOR SEVERAL WEEKS.

**SWELLING:** TREATMENT MAY CAUSE SWELLING, WHICH WILL USUALLY GO AWAY IN 3 TO 5 DAYS OR LESS.

**BRUISING:** TREATMENT MAY CAUSE BRUISING, BUT THIS IS EXTREMELY UNCOMMON.

**RESTRICTIONS:** I UNDERSTAND THAT IF I'VE HAD DERMA FILLER WITHIN THE PAST 2 MONTHS OR NEUROTOXIN (BOTOX, DYSPORT, JUVEDERM) WITHIN THE PAST 2 WEEKS, IT IS POSSIBLE THAT THE HEAT FROM THE ULTRA LIFT CAN BREAK DOWN AND DIMINISH THE EFFECTIVENESS OF THE DERMA FILLER OR NEUROTOXIN. I ALSO UNDERSTAND THAT FOLLOWING MY ULTRA LIFT TREATMENT, IT IS BEST TO AVOID DERMA FILLER FOR 2 MONTHS AND NEUROTOXIN FOR 2 WEEKS.

**CONSENT:** YOU HAVE READ THIS FORM AND UNDERSTAND IT. YOU REQUEST THE PERFORMANCE OF THE PROCEDURE DESCRIBED ABOVE. YOU HAVE BEEN GIVEN A COPY OF THIS CONSENT FORM UPON REQUEST. YOUR CONSENT AND AUTHORIZATION FOR THIS PROCEDURE IS STRICTLY VOLUNTARY. BY SIGNING THIS INFORMED CONSENT FORM, YOU HEREBY GRANT AUTHORITY TO PERFORM ULTRA LIFT.

THE NATURE AND PURPOSE OF THIS PROCEDURE, WITH POSSIBLE COMPLICATIONS, HAVE BEEN FULLY EXPLAINED TO YOUR SATISFICATION. NO GUARANTEE HAS BEEN GIVEN BY ANYONE AS TO THE RESULTS THAT MAY BE OBTAINED BY THIS TREATMENT.

I AGREE TO HAVE PHOTOGRAPHS TAKEN FOR DOCUMENTATION, AS WELL AS INTERNAL OFFICE USE.

I HAVE READ THIS CONSENT AND CERTIFY THAT I UNDERSTAND ITS CONTENTS IN FULL. I HAVE HAD ENOUGH TIME TO CONSIDER THE INFORMATION AND FEEL THAT I AM SUFFICIENTLY ADVISED TO CONSENT TO THIS PROCEDURE. I HEREBY GIVE MY CONSENT TO THIS PROCEDURE AND HAVE BEEN ASKED TO SIGN THIS FORM AFTER MY DISCUSSION WITH COLORADO BODY SCULPTING & REJUVENATION CENTER.

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**PATIENT SIGNATURE**

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**DATE**

# APPOINTMENT CANCELLATIONS

COLORADO BODY SCULPTING & REJUVENATION CENTER 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 MEDICAL FACULTIES.

TO ACCOMPLISH THIS, WE RELY UPON OUR PATIENT'S COMMITMENT TO KEEPING THE APPOINTMENTS THEY HAVE SCHEDULED FOR THEIR CONVENIENCE.

TO ENSURE THAT YOU ARE SEEN PROMPTLY AT YOUR DESIRED TIME, WE STRICTLY AVOID ANY OVERBOOKING.

YOUR TECHNOLOGIST IS ASSIGNED TO YOU AT THE APPOINTMENT TIME YOU HAVE REQUESTED.

COLORADO BODY SCULPTING & REJUVENATION CENTER'S UNIQUELY AFFORDABLE PRICING IS CAREFULLY CALCULATED UPON OUR PATIENTS' ABILITY TO KEEP THE APPOINTMENTS THEY HAVE COMMITTED TO.

AN AUTOMATED TEXT MESSAGE AND EMAIL WILL BE SENT TO REMIND YOU OF YOUR APPOINTMENT A DAY IN ADVANCE.

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 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 A PENALTY FEE. PLEASE BE ADVISED YOUR CANNOT BE SEEN UNTIL THAT FEE IS PAID IN FULL.**

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PATIENT SIGNATURE

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DATE