TheGlobalBeautyGroup
Technology for Beautiful Business

# Ultrasound Body Contouring Consent Form

Ultrasound Body Contouring works by targeting fat cells in the adipose tissue with high-frequency sound waves that shake the cell membrane to the point of rupture. This process breaks down and disperses the fat tissue, allowing it to reduce in size. The released fat is then taken on by the lymph system, exiting the body through natural sweat, urine and bowel movements.

## How it works:

Ultrasound body contouring treatment only works on the targeted unwanted fat cells and does not cause damage to the surrounding tissue. The body takes several days to complete the following treatment, which is why treatments are recommended at 72 hour to weekly intervals.

Typically, 5-10 treatments are required to achieve optimal results.

Body Contouring supports circumference reduction; it is not a weight loss program.

## Key factors to consider:

- The type of excess fat to be addressed – Genetic and environmental factors, including diet and lifestyle makes every human unique, so too their results.
- Exercise and a balanced diet should be incorporated in the program, to naturally encourage metabolism, thereby elimination of liquefied fat after treatment.
- Hydration pre and post treatment affects results.
- The crucial role that the lymphatic system plays after body contouring.
- High compliance required from the client.

For these reasons, the clients program should include (by a qualified professional):

1. Nutrition counselling (low caloric/fat/sugar diet)
2. Personal trainer (utilize liquefied fat/fatty acids as a source of energy)
3. Lymphatic drainage (immediately and in between treatments)
4. Hormone Testing

## Potential Side Effects:

- Localized Redness
- Localized Swelling
- Bruising
- Feeling Sluggish or Flu like symptoms
- Histamine response

## Please tick the following:

- ☐ Cancer
- ☐ Thrombosis
- ☐ Recent Illness
- ☐ Multiple Sclerosis
- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Pregnancy _____
- ☐ Phlebitis
- ☐ Light/Photo Sensitivity
- ☐ Metal Implants/Screws
- ☐ Asthma
- ☐ Lack of Normal Skin Sensation
- ☐ Epilepsy
- ☐ Hemophilia
- ☐ Heart Problems
- ☐ Hormonal Disorders
- ☐ Thyroid Disorders
- ☐ Recent Surgery
- ☐ Seizures
- ☐ HIV
- ☐ Pacemaker
- ☐ Claustrophobia
- ☐ Muscular Conditions
- ☐ Whiplash
- ☐ Lupus
- ☐ Hepatitis
- ☐ Alcoholism
- ☐ Smoking
- ☐ High/Low Blood Pressure
- ☐ Seizures

Allergies:_____

_____

Please list all medications that you take regularly:

_____

_____

## Client Release

I, _____ certify that the above statements are true and correct, and that I have been advised and fully informed of the fat cavitation procedure and the nature of the process proposed, along with all risks, reponses and pre and post care instructions. I hereby authorize and direct them to perform such process and perform such services as may be deemed necessary or advisable.

My signature below constitutes my acknowledgement that:

1. I have read, understand and fully agree to the foregoing
2. Understand the caution and contraindications for each process and service proposed
3. Give consent to the proposed process that has been satisfactorily explained to me and my questions have been addressed
4. I hereby give my consent and authorization voluntarily and release and its therapists of any claims that I have or may have in the future in connection with the described application or service.

Client Full Printed Name _____

Client Signature _____ Date _____

Witness Signature _____ Date _____

## Clinician Use only

### Circumferences:

Abdomen _____cm

Waist _____cm

Hip _____cm

Gluteal area _____cm

R Thigh _____cm L Thigh _____cm

R Arm _____cm L Arm _____cm

### Calliper Measurments:

Abdomen _____mm

Waist _____mm

Hip _____mm

Gluteal area _____mm

R Thigh _____mm L Thigh _____mm

R Arm _____mm L Arm _____mm

### Areas to be treated (please circle):