BODY CONTOURING TREATMENT CONSULT & CONSENT FORM

HOW DID YOU HEAR ABOUT US? _____ TODAY'S DATE _____

FIRST NAME _____ LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

HOME PHONE _____ MOBILE PHONE _____

EMAIL ADDRESS _____

BIRTHDAY _____ OCCUPATION _____

Body Contouring History

Have you had other aesthetic procedures for the body? _____

How did you hear about the CoolSculpting® procedure? _____

DO YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING?

Blood Disorders

- Active bleeding disorders *† ☐ YES ☐ NO
- Cryoglobulinemia * ☐ YES ☐ NO
- Paroxysmal cold hemoglobinuria * ☐ YES ☐ NO
- Cold agglutinin disease * ☐ YES ☐ NO
- Hemorrhagic conditions † ☐ YES ☐ NO
- Use of blood thinners * ☐ YES ☐ NO
- Raynaud's Disease * ☐ YES ☐ NO

Skin Disorders

- Sensitivity to Cold * ☐ YES ☐ NO
- Cold urticaria * ☐ YES ☐ NO
- Pernio or Chilblains * ☐ YES ☐ NO
- Open or infected wounds * ☐ YES ☐ NO
- Eczema, dermatitis, or rashes * ☐ YES ☐ NO
- Impaired skin sensation * ☐ YES ☐ NO

Implanted electrical devices:

- Cardiac pacemakers *† ☐ YES ☐ NO
- Cochlear implants † ☐ YES ☐ NO
- Intrathecal pumps *† ☐ YES ☐ NO
- Hearing aids † ☐ YES ☐ NO
- Defibrillators *† ☐ YES ☐ NO
- Neurostimulators *† ☐ YES ☐ NO
- Drug pumps *† ☐ YES ☐ NO
- Others (please specify) *† ☐ YES ☐ NO

_____

Nervous System Disorders:

- Seizure disorders † ☐ YES ☐ NO
- Epilepsy † ☐ YES ☐ NO
- Post-herpetic Neuralgia * ☐ YES ☐ NO
- Diabetic Neuropathy * ☐ YES ☐ NO

Graves' disease † ☐ YES ☐ NO
Thyroid Disorder * ☐ YES ☐ NO
Malignant tumor † ☐ YES ☐ NO
Heart problems † ☐ YES ☐ NO
Pulmonary insufficiency † ☐ YES ☐ NO
Liver disease * ☐ YES ☐ NO
Sensitivity to Isopropyl Alcohol or Propylene Glycol * ☐ YES ☐ NO
Fever (currently) † ☐ YES ☐ NO

In the treatment area:

- Skin that lacks normal sensation *† ☐ YES ☐ NO
- Metal or electronic implants † ☐ YES ☐ NO
- Recent surgical procedure or scars *† ☐ YES ☐ NO
- Poor Blood Flow * ☐ YES ☐ NO
- Hernia or history of hernia * ☐ YES ☐ NO

For female:

- Menstruating (currently) † ☐ YES ☐ NO
- Pregnant *† ☐ YES ☐ NO
- Lactating/breastfeeding * ☐ YES ☐ NO
- Copper IUD † ☐ YES ☐ NO

† CoolTone *CoolSculpting

I CONFIRM THAT THE ANSWERS I HAVE GIVEN ABOVE ARE CORRECT AND I HAVE NOT WITHHELD INFORMATION THAT MAY BE RELEVANT TO MY TREATMENT(S). I HEREBY RELEASE SENARA AND ITS EMPLOYEES FROM ANY AND ALL LIABILITY CONCERNING MY TREATMENT(S).

Print Name: _____ Signature: _____ Date: _____

In considering Medical Aesthetic treatments, please read the following information carefully and discuss any questions you may have with your physician. After you have read each statement, please **initial** each respective statement in the space that has been provided. Senara and it's associates reserve the right to deny treatment without signed consent from the patient named above.

COOLSCULPTING® INFORMED CONSENT

BACKGROUND

The CoolSculpting® procedure is a non-invasive procedure that is intended to change the appearance of the treatment area by delivering controlled cooling at the surface of the skin to break down fat cells that are just beneath the skin. This procedure is not a treatment for obesity or a weight-loss solution. The CoolSculpting procedure does not replace traditional methods such as diet, exercise or liposuction.

Clinical studies of a treatment site have shown that the CoolSculpting procedure can break down fat cells to change the appearance of visibly localized bulges of fat that is just beneath the skin on the abdomen, thighs, flanks and submental area. The submental area is the area under the chin. Following the procedure, the treated fat cells are naturally processed by the body. Visible results can vary from person to person.

Patient Initials: _____ **Date:**_____

POTENTIAL SIDE EFFECTS & RISKS

I understand that there are potential side effects that can occur, including, but not limited to, the following:

- The suction pressure of a vacuum applicator may cause sensations of deep pulling, tugging and pinching.
- A surface applicator may cause sensations of pressure.
- You may experience intense cold, stinging, tingling, aching or cramping as the treatment begins. These sensations generally subside during treatment as the area becomes numb.
- You may have dizziness, lightheadedness, nausea, flushing, sweating, or fainting during or immediately after the treatment.
- The treated area may look or feel stiff after the procedure and transient blanching (temporary whitening of the skin) may occur. These are all normal reactions that typically resolve within a few minutes.
- Bruising, swelling, redness, cramping and pain can occur in the treated area and the treated area may appear red for one to two weeks after treatment.
- After submental area treatment, a feeling of fullness in the back of the throat may occur. Initial if the submental area is to be treated. If the area under the chin is not being treated, please write N/A.
- You may feel a dulling of sensation in the treated area that can last for several weeks after the procedure. Prolonged swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/or skin sensitivity also have been reported.
- Paradoxical Hyperplasia -- A small number of patients have experienced gradual development of a firmer enlargement, of varying size and shape, of the treatment area, known as "paradoxical hyperplasia", in the months following the treatment. If such paradoxical hyperplasia occurs, it will be distinguishable from temporary swelling and will probably not resolve on its own. The enlargement/lump can be removed by means of a surgical procedure such as liposuction.
- Treatment area demarcation -- A small number of patients have experienced excessive fat removal in the treatment area, resulting in an unwanted indentation. The indentation may be improved through corrective procedures.
- In rare cases, patients have reported the CoolSculpting treatment area to have darker skin color, hardness, discrete nodules, frostbite (local injury due to cold), hernia or worsening of pre-existing hernia. Surgical intervention may be required to correct hernia formation.
- Patient experiences may vary. Some patients may experience a delayed onset of the previously mentioned symptoms. Contact your physician immediately if any unusual side effects occur or if symptoms worsen over time.

Patient Initials: _____ **Date:**_____

CONTRAINDICATIONS

- Active applicator should never be placed over hernias, areas of scar tissue, or surgical areas
- CoolSculpting should be used with caution or not at all for patients with active or chronic skin or neurological conditions.
- Patients with Raynaud's Disease, or other disorders that are impacted by cold or create a sensitivity to cold should not be treated with CoolSculpting.

Patient Initials: _____ **Date:**_____

EXPECTED CLINICAL OUTCOME

- You may start to see changes in as early as three weeks after your CoolSculpting procedure, and will experience the most dramatic results after one to three months. Your body will continue to naturally process the injured fat cells from your body for approximately four months after your procedure. Initial:
- Results vary from person to person. You may decide that additional treatments are necessary to achieve your desired outcome. Although highly unlikely, it is possible that you will not experience any noticeable result from the procedure.

Patient Initials: _____ **Date:**_____

COOLTONE™ INFORMED CONSENT

BACKGROUND

The CoolTone™ treatment is a noninvasive procedure that is intended to firm and tone the treatment area by delivering controlled electromagnetic stimulation to induce strong muscle contractions. This procedure does not replace traditional healthy behaviors, such as exercise and diet.

The CoolTone procedure is intended to provide noninvasive electromagnetic stimulation for the improvement of abdominal tone, strengthening of the abdominal muscles, development for firmer abdomen, and strengthening, toning, and firming of buttocks and thighs. Results may vary.

Patient Initials: _____ **Date:**_____

TREATMENT SAFETY

Due to the strong magnets used for treatment, just like an MRI, we ask that you remove ALL metal objects from your person or from the vicinity of the machine before we begin. **It is the patient's responsibility to remove all objects listed below and to inform the Senara technician of any problematic items prior to the start of treatment.** This includes:

- Jewelry and Piercings in the treatment area
- iWatch, FitBit, or other Smart Devices
- Cell Phones, Tablets, Laptops
- Clothing with metal grommets or snaps or metallic fibers
- Credit Cards
- Any other item that might be impacted by the magnets

Patient Initials: _____ **Date:**_____

POTENTIAL SIDE EFFECTS & RISKS

I understand that there are potential side effects that can occur, including, but not limited to, the following:

- Muscular pain in the treatment area following the CoolTone treatment
- Temporary muscle spasm, joint or tendon pain in the treatment area
- Redness at or near the treatment site

Patient Initials: _____ **Date:**_____

CONTRAINDICATIONS

- Active applicator should never be placed over implanted electrical or metallic devices like cardiac pacemakers, cochlear implants, intrathecal pumps, copper IUDs, hearing aids, etc.
- CoolTone should be used with caution in persons with Graves' disease, active bleeding disorders, or seizure disorders.
- Women who are close to menstruation may find that it comes sooner, or cramping is increased / intensified with CoolTone treatments. Therefore, it is not recommended to undergo treatment during this time of the month. I understand that this and other unknown side effects may occur.

Patient Initials: _____ **Date:**_____

EXPECTED CLINICAL OUTCOME

Ideal response to CoolTone treatment is a visible firming and toning in the treatment area. Results vary from person to person. Additional treatments may be necessary to achieve desired outcome. Although highly unlikely, it is possible that some patients may not experience any noticeable result from the procedure.

Patient Initials: _____ **Date:**_____

ZWAVE® CELLULITE REDUCTION INFORMED CONSENT

BACKGROUND

This document is intended to serve as confirmation of informed consent for Extracorporeal Shock Wave Therapy (ESWT) as ordered by your medical practitioner (Practitioner) for the purposes of Cellulite Reduction.

ESWT therapy is a non-invasive technique that uses pulsatile waves to stimulate blood flow to the applied area. ESWT is a safe procedure and has been used for a variety of health conditions.

When a medical device is approved for use by the Food and Drug Administration (FDA), the device manufacturer produces a "label" to explain its use. Once a device is approved by the FDA, physicians may use it "off-label" for other purposes if they are well-informed about the device, base its use on firm scientific method and sound medical evidence, and maintain records of its use and effects.

The ESWT device used in the therapy is cleared by the FDA for intended use as a treatment for minor aches and pains and for the temporary increase in local blood circulation.

The ESWT device is being used in the therapy as an "off-label" use. This usage is based upon scientifically designed, international clinical studies that have shown ESWT to be effective in temporarily reducing the appearance of cellulite.

Patient Initials: _____ **Date:**_____

POTENTIAL SIDE EFFECTS & RISKS

Although ESWT has been performed on thousands of patients and the risks are very low, we must list them. I understand the most common risks associated with the proposed procedure(s) to be: swelling, reddening of skin, soreness. Less common risks to the proposed procedure(s) to be: hematoma (bruising), petechiae (minor broken blood vessels). Side effects normally resolve within a few days.

Patient Initials: _____ **Date:**_____

EXPECTED CLINICAL OUTCOME

The purpose of this procedure is to reduce the appearance of cellulite in the areas indicated above. The procedure requires more than one treatment and may produce reduction in the appearance of cellulite. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments so the outcome cannot be guaranteed.

Scientific studies have shown that when applied to an area, ESWT increases blood flow, by stimulating the growth of new blood vessels (neovascularization) and growth factors thus enhancing tissue growth and repair.

After the initial round of treatments, ongoing treatments are recommended for optimal, continued results.

Patient Initials: _____ **Date:**_____

CONSENTS & ACKNOWLEDGEMENTS

Before subjecting yourself to any Clinical Procedure(s), read carefully the following statements. After you have read each statement, please **initial** each respective statement in the space that has been provided.

Initial

____ I hereby authorize Senara medical staff and such assistants as may be selected at Senara to perform the procedures and treatments outlined in this consent document.

____ I understand the risks, contraindications, and potential side effects of the Clinical Procedures as detailed in the informed consent for treatment. I understand that this list is not meant to be inclusive of all possible risks associated with these treatments as there are both known and unknown side effects associated with any medication or procedure.

____ I recognize that during the course of the treatment, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.

____ I understand there is no guarantee of results of any treatment, and that more than one treatment will be needed to achieve a satisfactory result. I understand the regular charge applies to all subsequent treatments. I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

____ I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

____ I hereby assume all Risks, hazards and costs of care or expense associated with or which may arise from such treatment, hereby releasing the personnel and consultants and any sponsoring health care facility or institution and its affiliates and all of their agents and employees from any liability from said treatment except where such risks and hazards are the proximate result of gross negligence. This constitutes the full disclosure and supersedes any previous verbal or written disclosures, advertising or marketing materials prepared by us or other. It is understood that our programs are specialty services and do not have responsibility for your comprehensive medical care.

____ I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

____ I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. My name will not be used to identify these photographs. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed.

____ I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

____ I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

____ I certify that I am NOT pregnant. (Female patients)

____ I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

If you have any medical problems that arise while participating, please keep us informed. If an urgent medical problem should arise and you have a concern that it may be related to your care, please call us at 309.693.9600 and contact your primary care physician or go to a healthcare facility to have the problem assessed immediately.

Signature: _____ Date: _____

Print Name: _____

Technician: _____ Date: _____

Witness: _____ Date: _____