(954) 443-2420
7900 Northwest 33rd Street
Suite 104 – 106
Hollywood, FL 33024

MEDICAL AND DISCLAIMER FORM

Name: ______________________ Date of Birth: ______________________ Sex: Female/Male
Address: ____
Telephone: ______________________ Mobile: ______________________
Email: ____
Areas of Concern: ____
How did you hear about us: ____

Are you currently or have suffered from any of the following:

❍Yes ❍No Comments: ______________________________

Kidney/ Liver Disease:

❍Yes ❍No Comments: ______________________________

Heart Disease:

❍Yes ❍No Comments: ______________________________

Cancer:

❍Yes ❍No Comments: ______________________________

Currently Pregnant:

❍Yes ❍No Comments: ______________________________

Medical Edema:

❍Yes ❍No Comments: ______________________________

Auto immune disease:

❍Yes ❍No Comments: ______________________________

Any metals pins or plates:

❍Yes ❍No Comments: ______________________________

Thyroid problems:

❍Yes ❍No Comments: ______________________________

Urinary infection:

❍Yes ❍No Comments: ______________________________

Diabetes:

Any condition already being treated by a medical practitioner:

____
____
____
____

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Please read carefully and only sign if you are in full agreement with its contents

I ________________________ confirm that I have understood the treatment and the above medical information is accurate. I am willing to proceed without confirmation from my own primary physician or medical consultant. I hereby indemnify the therapist against any adverse reaction sustained as a result of the treatment and confirm that all the information I have given is accurate.

It is your responsibility and not that of Trivectar Technologies , Staff to consult your primary physician before treatment.

I hereby indemnify Trivectar Technologies , Staff against any adverse reaction sustained as a result of the treatment and confirm that all the information I have given is correct.

Signed.. Date............/.........../............

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Treatment Consent Form

Title (Mr/Mrs/Miss): ____
Client Name: ____
Adress: ____
City, Zip code, State: ____

I authorize Trivectar Technologies , (iShape Aestheics) to perform the procedure(s) for the purpose of body contouring, improving the appearance of cellulite and/or skin tightening. I am aware that clinical results may vary depending on individual factors, including medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. I have been made aware that my diet and the amount of exercise I do will have a major effect on the results of my treatments. If I do not make address my diet and exercise I am aware that the maximum results may not be achieved and/or retained.

I understand that treatment by (iShape Aesthetics) involves a series of treatments. The fee structure has been fully explained and I understand that I am required to pay for treatments prior to or at the time of service. I am fully aware that should I wish to cancel the series, the value of the outstanding treatment is non refundable.

Due to demand for treatments we schedule all appointments following the initial consultation. Please be aware that all cancellations require a minimum of 24 hours notice. Failure to do so will result in that treatment being deducted from your course without a refund. It is important to be aware that this may have a negative effect on your overall results. Any changes to the initial treatment dates will be subject to availability. If you are more than 5 minutes late for an appointment we may not be able to accommodate your treatment appointment. In this instance Ausmed International Pty Ltd reserves the right to deduct a treatment from your treatment course without a refund.

I certify that I have been fully informed of the nature and purpose of the (iShape Aesthetics) 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 a cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I am aware that the treatment, may cause slight hypo/hyper-pigmentation of the skin and treatment is taken at my own risk.
I understand that it is my personal responsibility to inform Ausmed International Pty Ltd, of any changes to my medical history during the course of treatment sessions and I confirm that should this occur I shall advise the staff of any changes.

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I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.
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.

Client Signature:_____________________________ Date: _____/______/_______
Witness Signature: ___________________________ Date: _____/______/_______

MEASUREMENT FORM

CLIENT NAME:____
EMAIL:____ PHONE:_________________________________
AREA BE TREATED: ABS/ FLANK/ THIGHS/ HIPS/ OTHER: _______________________________________
LAST AND UPCOMING MENSTRUAL CYCLE: ____

(BELOW FOR OFFICE USE ONLY)

WEIGHT (LB): _____ BMI/CATEGORY: _____ PRE-MEASUREMENT (INCH/CM): _____
POST-MEASURE (INCH/CM): _____ LOSS: _____

Measurement Site	A	B	C	A	B	C
Above Ground (in)						

Treatment Number: ________________ Date: ___ / ___ / _____

1 ____

2 ____

3 ____

4 ____

5 ____

6 ____

7 ____