Patient Treatment Consent Form

I duly authorize the practitioners of Intracoastal Chiropractic Clinic to perform the iLipo procedure for the purpose of spot fat reduction/improving the appearance of cellulite. I am aware that clinical results may vary depending on individual factors, including medical history, client 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 an effort to address my dietary requirements and exercise, I am aware that the results achieved may not be retained.

I understand the treatment involves a course of treatments. The fee structures has been fully explained and I understand that I am required to pay for a course of treatments prior to any procedures taking place. I am fully aware that should I wish to cancel the course, the outstanding treatment value is non-refundable.

I verify that the course cost is $_____ for_____ 20 minute treatments. (Patient Initials)_____

I understand that a minimum of 2 hours notice is required to cancel or change an iLipo appointment. I also understand that a $25.00 fee will be charged to my account if the cancellation occurs without the 2 hour notice.

Patient Signature_____Date_____

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 a cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I understand that it is my personal responsibility to inform the practitioner of the clinic named above of any changes to my medical history during the course of iLipo treatment sessions and I confirm that should this occur I shall advise the practitioner of any changes.

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 opportunity to ask questions, any questions have been answered to my satisfaction and that I have fully read and understood the contents of this consent form.

Patient Name (Printed):_____

Patient Signature: _____Date: _____

Practitioner Signature: _____Date:_____