

# EMSCULPT<sup>neo</sup>®

<b>Patient's name:</b>	<b>Date of birth:</b>
<b>Phone:</b>	<b>Email:</b>
<b>Address:</b>	

You are scheduled for a series or a single non-invasive treatment/s with the Emsculpt Neo®.

EMSCULPT NEO® is indicated for non-invasive lipolysis (breakdown of fat) of the abdomen and thighs and reduction in circumference of the abdomen and thighs with Skin Type I to Skin Type VI; and for non-invasive lipolysis (breakdown of fat) of the upper arms limited to skin types II and III and BMI 30 or under. EMSCULPT NEO® is also indicated for improvement of abdominal tone, strengthening of the abdominal muscles, development of firmer abdomen; strengthening, toning, and firming of buttocks, thighs, and calves; and improvement of muscle tone and firmness, for strengthening muscles in arms. **Initials:** \_\_\_\_\_

Your treatment provider will discuss your specific treatment needs. The recommended number of treatments is 6. The treatment is typically about 20-30 minutes per session, with sessions separated by 5 to 10 days for HIFEM+RF Advance/Gentle protocol. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments, depending on your goals. **Initials:** \_\_\_\_\_

Before the treatment, no unusual preparations are required; however, keeping your body well hydrated is strongly recommended. On the day of the treatment, you are advised to wear comfortable clothing that allows flexibility for correct positioning during the treatment. To avoid excessive sweating, the treated area should be shaved, or hairs in the treatment area should be trimmed before the treatment. Also, the treated area will be wiped with alcohol wipes before treatment to remove any moisture, perfume, moisturizers, or oils. You will be asked to remove all metallic accessories and electronic devices. **Initials:** \_\_\_\_\_

I acknowledge that a successful treatment outcome can be affected by smoking, excessive alcohol consumption, eating disorders, or ongoing medication. While no special diet is required, you are encouraged to eat healthy to help promote and maintain results. **Initials:** \_\_\_\_\_

The treatment does not require anesthesia. During the application, you will feel intense muscle contractions and a heating sensation in the treated area. It is important to note that during the treatment the heating sensation may be intense, but it should never be painful. Please ask your provider to re-adjust the intensity should you feel any pain or discomfort. The procedure doesn't require any recovery time. **Initials:** \_\_\_\_\_

I am aware that I **MUST NOT** wear any metallic accessories (such as jewelry, watch or clothes containing metallic threads or metallic accessories) during the treatment. I also acknowledge that I do not have any metallic or electronic implants (such as pacemakers, defibrillators, metallic IUDs, etc.). **Initials:** \_\_\_\_\_

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Do you experience urine leakage or frequent urination? ☐ No ☐ Yes

Do you suffer from any bladder problems? ☐ No ☐ Yes If yes, explain \_\_\_\_\_

**Please answer whether you currently have or had any of the following in the past\*:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| ▪ Electronic implants (cardiac pacemakers, defibrillators, neurostimulators) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Metal implants   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Drug pumps   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Malignant tumor  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Pulmonary insufficiency  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Injured or otherwise impaired muscles                                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Cardiovascular diseases  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Disturbance of temperature or pain perception                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Hemorrhagic conditions   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Septic conditions and empyema  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Systemic or local infection such as osteomyelitis and tuberculosis         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Contagious skin disease  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Elevated body temperature  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Pregnancy, postpartum period, nursing and menstruation                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Graves' disease  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Metallic IUD   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Recent surgical procedures (muscle contraction may disrupt the healing)    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Areas of the skin which lack normal sensation                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**If you answer YES to any of these questions, please specify:**

**Please answer the following:**

Have you been pregnant? ☐ YES ☐ NO C-section ☐ Vaginal birth ☐

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| ▪ Are you satisfied with the appearance of your abdomen?    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Are you satisfied with the strength of your core muscles? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▪ Are you satisfied with the shape of your buttock?         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

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- Are you satisfied with the tone of your arms? ☐ YES ☐ NO
- Are you satisfied with the tone of your calves? ☐ YES ☐ NO
- Are you satisfied with the appearance of your thighs? ☐ YES ☐ NO

## Treatment considerations

- I am aware that as is the case with every heat-based therapy, in rare cases, burns can occur.  
**Initials:** \_\_\_\_\_
- I am aware that the applicators should always be in direct contact with the skin. I am aware that treatment should not be applied over clothing or scar tissue. **Initials:** \_\_\_\_\_
- I understand that there are certain side effects associated with EMSCULPT NEO treatments. The side effects may include, but are not limited to muscular pain, intramuscular fat decrease, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness, increased menstrual flow in female patients and panniculitis. **Initials:** \_\_\_\_\_
- I understand that the treatment over injured or otherwise impaired muscles is contraindicated  
**Initials:** \_\_\_\_ I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. **Initials:** \_\_\_\_\_
- I agree to before and after treatment photographs, measurements and weighing, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. **Initials:** \_\_\_\_\_
- I understand results may vary and that an exact result cannot be predicted. Completing a full treatment series is necessary to maximize treatment efficacy. It is possible that you will not feel any recognizable results after the procedure. I acknowledge results may not meet my expectations. **Initials:** \_\_\_\_\_
- I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure, and possible side effects. **Initials:** \_\_\_\_\_
- I have read the above information, and I request and give my consent to be treated with the EMSCULPT NEO by the physician(s) in this practice and his/her designated staff. **Initials:** \_\_\_\_\_

My signature below indicates that the above information is accurate and current.

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness (in print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## TREATMENT RECORD

Patient's name or ID: \_\_\_\_\_

Treatment area(s): \_\_\_\_\_

Height: \_\_\_\_\_ || Age: \_\_\_\_\_

SESSION #	DATE	PRESET	TREATMENT TIME	HIFEM INTENSITY	RF INTENSITY	CIRCUMFERENCE MEASUREMENT	WEIGHT (each visit)	PHOTOS (each visit)	PROPERLY HYDRATED	OPERATOR INITIALS
1								YES/ NO	YES/ NO	
2								YES/ NO	YES/ NO	
3								YES/ NO	YES/ NO	
4								YES/ NO	YES/ NO	
5								YES/ NO	YES/ NO	

**COMMENTS:**