TREATMENT CONSENT FORM

I duly authorize the technicians of **Lipo-Light, LLC** to perform the procedure for the purpose of body contouring, lymphatic drainage, and improving the appearance of cellulite. 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 an effort to address my diet and exercise I am aware that the results achieved may not be retained.

I understand that treatment by **Lipo-Light, LLC** involves a course of treatments.

I certify that I have been fully informed of the nature and purpose of the **Lipo-Light** 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 **Lipo-Light** may cause slight hypo/hyper-pigmentation of the skin and treatment is taken at my own risk (tattoo areas should be avoided).

I understand that it is my personal responsibility to inform the therapist of any changes to my medical history during the course of treatment sessions and I confirm that should this occur I shall advise the therapist/ staff of any changes.

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 confirm that I have understood the treatment and the medical information I provided is accurate. I am willing to proceed without confirmation from my own primary physician or medical consultant. You should note that if the therapist is unable to explain to you the contra indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your primary physician. 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 correct.

Name_____

Client signature …… Date ……/……/……..