re:sculpt

re:sculpt
910 Waukegan Road
Glenview, IL 60025

(p) 847.657.0881
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Pressurotherapy and/or Vacuomobilization Intake:

Name: _____

Address _____

City _____ **State**_____ **Zip**_____

Phone: (PLEASE CHECK THE PREFERRED NUMBER FOR MESSAGES)

_____

❍ HOME ❍ WORK ❍ CELL

What's the earliest/latest we can phone your home?

_____

Email_____

Date of Birth: _____ **Gender Identity:** _____

Medical / Surgical History

I have:

Deep vein thrombosis	❍ YES	❍ NO	**Claustrophobia**	❍ YES	❍ NO
Acute infection of limbs	❍ YES	❍ NO	**Pacemaker**	❍ YES	❍ NO
Heart Failure	❍ YES	❍ NO	**Hypothyroidism**	❍ YES	❍ NO
Asthma	❍ YES	❍ NO	**Presence of pain**	❍ YES	❍ NO
1st trimester pregnancy	❍ YES	❍ NO	**Presence of insensitivity**	❍ YES	❍ NO
Severe exzema	❍ YES	❍ NO	**Hemophilia**	❍ YES	❍ NO
Epilepsy	❍ YES	❍ NO	**High blood pressure**	❍ YES	❍ NO
Emphysema	❍ YES	❍ NO	**Coumadin**	❍ YES	❍ NO

Significant Disease_____

Circulatory Condition_____

Pregnancies_____

Surgeries_____

Incisions_____

Current Mediation_____

Birth Control / Hormonal Treatment

_____

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Allergies _____

Beauty Surgery History _____

Nutrition

Recent Weight Gain _____

Current Diet _____

Alcohol/Smoking _____

Target Weight _____

Physical Activity

Frequency / Duration _____

Type _____

How Long _____

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client consent for pressurotherapy and/or vacuomobilization procedure:

I hereby request and authorize_____ to provide and administer PRESSUROTHERAPY/VACUOMOBILIZATION procedure as it has been explained and described to me by _____.

I understand that Pressurotherapy is a compression technique designed to help improve overall circulation and tone-up the circulatory system for faster detoxification and elimination, fluid clearance, slimming and firming, toning and oxygenation. A computer controlled pump inflates the individual sections of the multichambered garment, which are positioned around the limbs. The pump inflates each chamber of the garment individually. The contra-indications for use of pressurotherapy are infection, open wound, asthma, blood clots, first trimester of pregnancy or history of miscarriages and severe eczema, deep vein thrombosis, cardiac heart failure, and pacemaker. The treatment should not be administered when client is taking medications for the following conditions: heart, hemophilia, asthma, or high blood pressure, or taking steroid medications or Coumadin.

I understand that Vacuomobilization is a process of applying a vacuum to the skin through precise maneuvers utilizing cup sizes to match the surface of the treated body area. This non-invasive procedure actually stimulates the natural functions of the body and therefore remains both safe and comfortable while efficient and beneficial on many levels. The maneuvers lift up the skin with the aid of suction. The purpose of this procedure includes scar and burn therapy, lymphatic drainage, contouring, oxygenation and an increase I metabolism, elimination of toxins, body contouring including cellulite.

The contra-indications for use of vacuodermie vacuomobilization are: any infection or pathology in their active phase, any acute or inflammatory disease, redness, bruises, hematomas, dematosis, infectious or mycotic disease, skin tumors, open wounds, vein thrombosis in its acute phase, fragile venous or lymphatic capillary system, recent fractures and bone grafts. The treatment should not be administered when client is taking medications for the following conditions: heart, hemophilia, asthma, or high blood pressure, or taking steroid medications or Coumadin.
The details of the technique application have been depicted during the initial consultation in addition to written explanation as above. I am fully aware of the small risks to the treatment including the sensitivity reaction and minor bruising.

I understand the indications for use include secondary and primary lymph edema, post thrombosis edema, hypodermic inflammations, varicose or post thrombosis ulcers, lypodystrophy, face contouring and wrinkles. I have divulged all significant

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information regarding my medical history and answered all health related questions and will advise you of any changes in my health.

During the consultation, it was mentioned that the treatment results may vary from person to person and no guarantees have been made to me. All personal information in this Consent will remain strictly confidential and will not be disclosed without my consent in writing. I assume all risks involved and give consent for the duration of my treatment to all of the above described. I have asked my personal primary physicians any questions that I have concerning the Procedure and its risks. I understand that I am obligated to advise re:fit, inc of any changes in my medical condition as long as I continue to receive the Procedure. I am aware that the Procedure may involve certain risks of injury. In consideration of re:sculpt, inc's services in connection with the Procedure, to the fullest extent allowed by law, I assume the risk of any and all accidents, illness and injuries of any kind which may be sustained by me by reason of or in connection with my Procedure. In addition, I agree that, to the fullest extent allowed by law, neither re:sculpt, inc's nor any of its owners, agents, employees, personal representatives, successors, or assigns shall be liable or responsible for or on account of any such accident, illness, or injury, and I release, discharge, and absolve refit and its owners, agents, employees, personal representatives, successors or assigns from any an all liability and responsibility for or on account of any such accident, illness, or injury. To the fullest extent allowed by law, I shall indemnify, defend and hold harmless refit, its owners, agents, employees, personal representatives, successors, or assigns from any and all losses, liabilities, damage, costs and obligations (or actions or claims in respect thereof) (including reasonable counsel fees), which may suffer or incur, insofar, as such losses, liabilities, damages, costs or obligations (or actions or claims in respect thereof) arise out of or are based upon or are in any way connected with the Procedure.

This Agreement Consent shall be binding upon my heirs, legatees, personal representatives, successors and assigns.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO BE BOUND BY IT.

_____

Client Signature Date

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Client Cancellation and Payment Policy

Re:sculpt, llc clients are seen by appointment only. Scheduling is based on a first come first served basis. To receive the full benefit of your session, please arrive on time.

Cancellation Policy

Cancelling An Appointment With No Charge: To cancel an appointment with no charge we require a twenty-four (24) hour notice. This notice must be given directly to re:sculpt, llc by calling 847-657-0881. Notice provided to your practitioner is not sufficient.

Cancellation Fee: If you call re:sculpt, llc directly and cancel your appointment within 24 hours of the scheduled appointment time, the cancellation fee will be 60% of the fee of service.

Full Price Required: If you do not call to cancel an appointment, you will be charged the full price of the session.

Payment Policy: Payment is due at time of service. Check or cash is accepted. Cancellations will be billed to the credit card of your choice.

_____ _____ _____
TYPE NUMBER EXP. DATE

By signing below, I agree to abide by the Cancellation and Payment Policies of re:sculpt, llc.

_____
CLIENT'S SIGNATURE

_____
DATE