CONTOUR LIGHT

Patient Intake Form

Your success is our #1 priority.

Help us to help you achieve that success by filling out this questionnaire as completely as possible.

Name: _____ Date: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Height: _____ Weight: _____

Age: _____ Sex: _____

Marital Status: _____

Occupation: _____ Favorite Hobbies: _____ _____

Do you enjoy your work? _____

Do you feel stress (explain)? _____

Are you currently under the care of a physician? _____

Do you exercise? _____ How often? _____ What type? _____

Do you get angry often? _____ Are you happy (if not, why)? _____

What worries you most? _____

What do you expect from your Contour Light treatment? _____

Why did you choose Contour Light? _____

If you were referred by one of our former clients, please tell us who we can send a Thank

You note to: _____

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Weight Loss

How long have you been overweight? _____

How much weight have you decided to lose? _____

How many times have you failed at weight loss? _____

What methods failed to help you lose weight? _____

Does your weight problem make you physically uncomfortable (explain)? _____

Does your excessive weight limit you and your activities (explain)? _____

How many times a year do you diet? _____

Do you suffer from uncontrollable cravings (explain)? _____

Do you feel out of control? _____

Do you eat because of emotions (explain)? _____

Is successful weight loss a top priority (explain)? _____

What new activities will you become involved in after losing weight? _____

Are other members of your family overweight? _____

Briefly describe your eating behavior: _____

Do you believe weight loss has to be painful? _____

Do you believe weight loss can be enjoyable? _____

How fast do you want to be thin, trim, and fit? _____

Do you feel your eating behavior is normal? _____

Does your family support your weight loss efforts? _____

Does being overweight limit your social life? _____

Do you feel tired, run down, and out of energy? _____

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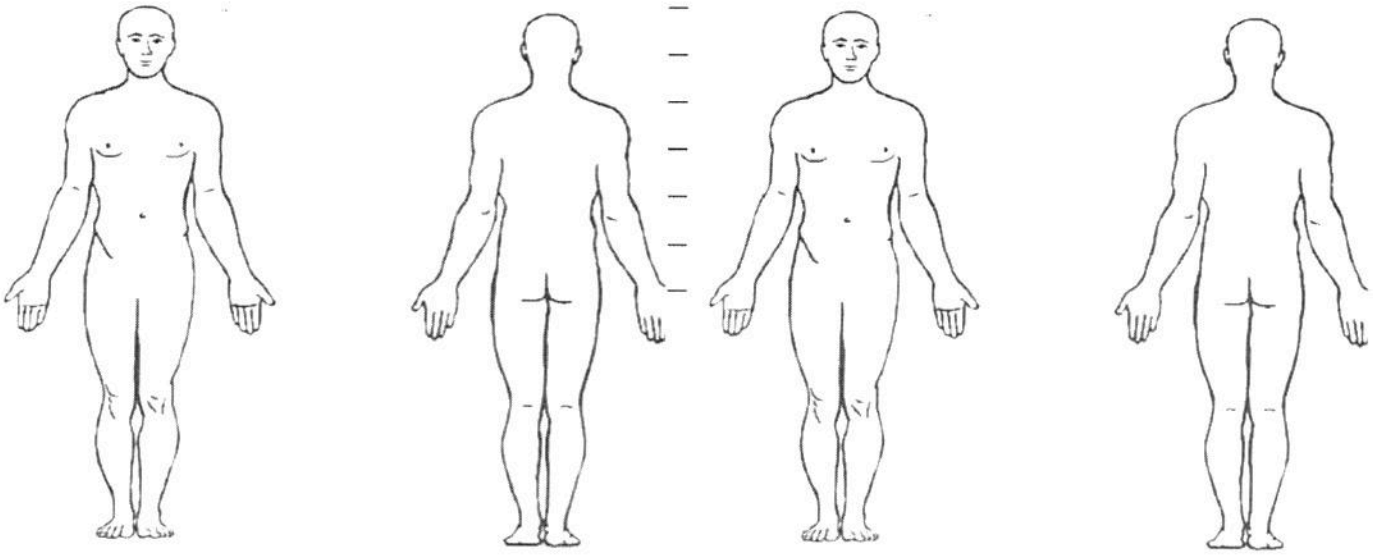
Areas Of Your Body That You Want To Change



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Treatment Disclosure Form

Name:

First _____ Last: _____ D.O.B. _____

Program and Background

You have requested treatment utilizing Contour Light LED light therapy manufactured by Contour Research, LLC. This treatment is the application of a 635 nm light, which has been proven in multiple clinical studies to stimulate the mitochondria of adipose (fat) cells to expel the cell's contents, which will then accumulate in the body's interstitial space. This excess fat is moved by the body's lymphatic system and excreted without negative side effects or downtime. Any medical or cosmetic procedure carries risks, complications and varied results. The purpose of this document is to inform of the patient of the nature of this product and its risk.

Procedure

Initially you will consult with a Contour Light therapist to determine if you are a candidate for the LED therapy. You will have the opportunity to ask questions or voice concerns you may have regarding this treatment. If it is determined you are a candidate for this procedure, then paperwork, measurements, pre and post treatment photos (upon your approval) and suggested course of treatment will be given. The treatment is administered by placing LED pads on the desired area(s) to be treated. It is recommended that a patient will need a minimum of 9 – 12 treatments for the light therapy to achieve the desired effect. This treatment should be used in conjunction with a healthy diet and exercise program. You should consult a health care professional before beginning any new exercise program to determine if your body is physically able to receive these treatments.

Risks/Discomfort

This treatment is non-invasive. During treatment there should be no discomfort. You will feel the warmth of the light and the weight of the light pads. Contour Light is suitable for anyone over 18. Anyone suffering from the following would not be suitable for this treatment:

- Pregnant or breast feeding
- Kidney or liver disease/disorder
- Cancer, active or within 1 year of remission
- Heart disease
- Pacemaker
- Autoimmune disease
- Metal pins/plates
- Thyroid disorders
- HIV/AIDS
- Hepatitis C or D
- Serious Mental Disorder
- Epilepsy
- Gall Bladder Disorders or if Gall Bladder has been removed (Cholecystectomy)
- High blood pressure or high cholesterol or a combination thereof
- Alcohol or Drug addiction (will reduce treatment efficacy)

Benefits

LED Light therapy has become more prominent and has been used in many studies for pain management and recently by cosmetic surgeons to emulsify adipose tissue before liposuction with FDA approval. The potential benefit of this treatment is body contouring without surgery. Problem areas or excess pockets of fat can be targeted, however the most commonly treated areas are the stomach, hips, flanks, and thighs. In clinical trials, patients have averaged 2-5cm lost from their stomach, hips, and thighs. Results vary and there is no guarantee implied or suggested that desired results will be achieved.

Voluntary Cosmetic Procedure

_____ Initial I understand that this is a strictly a voluntary cosmetic procedure. No treatment is necessary or required and the Contour Light LED therapy has been chosen by myself (the patient).

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_____ Initial I have been informed of the potential risks and side effects of Contour Light including but not limited to redness, swelling, heat sensitivity, pain, increase bowel movements and increased urination. The risks, potential damages and adverse side effects have been explained to me and I fully understand.

_____ Initial I understand that a minimum of 9 - 12 treatments is required to achieve full results at an average BMI of 25 to 30. A BMI of over 30 (which is considered in the obese range) requires a specific strategy moving forward with the minimum recommendation of 24 + treatments. At that point, I will be re-evaluated to see if more sessions are needed in order to achieve realistic goals. Each body is different and may require more or less treatments depending on the patient's diet, exercise, metabolism and body type. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program.

_____ Initial I know that if after the treatment course I gain weight, the results of the Contour Light may be reversed.

_____ Initial I understand that no guarantee has been given as to the results that may be obtained by this treatment. I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information and feel I am sufficiently advised to consent to this procedure. I hereby give my consent to have this procedure. If at any time during the Contour Light procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/or terminate the session at my discretion.

_____ Initial I duly authorize technicians to perform the procedure for the purpose of body contouring, lymphatic drainage, improvement of cellulite and skin tightening. I am aware that clinical results may vary depending on individual factors, medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. If I do not make an effort to address my diet and exercise, the results achieved may not be retained.

_____ Initial I have reviewed this consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form, I grant authority for your technician to perform the described treatment on me. The purpose of this procedure, risks, complications, alternative methods of treatment have been fully explained to my satisfaction. Cosmetic indications for these procedures include but are not limited to cellulite reduction, treatment of problem fat areas, skin tightening, and skin rejuvenation. Increased redness to the area for up to 12 hours may be experienced (although this is unlikely). Normal activities may be resumed following the treatment. Any photos taken will be used to show the patients progress and may be used in marketing ads.

_____ Initial I authorize the release of my photos to be used by the clinic performing these treatments and to be used by Contour Research, LLC for promoting the Contour Light device.

Questions and Explanations

By signing below, you certify that this procedure has been explained to you and to your satisfaction, and that you have been fully informed of the nature and purpose of the Contour Light procedure, expected outcomes and possible complications, and understand that no guarantee can be given as to the final result obtained. You are fully aware that your condition is of a cosmetic concern and that the decision to proceed is solely based upon your expressed desire to do so. You are aware that Contour Light may/can cause slight hypo/hyper-pigmentation of the skin and treatment is taken at your own risk (tattoo areas should be avoided). Any further questions can be directed to a Contour Light Specialist. You further state that you are of lawful age and legally competent to sign this aforementioned release, and that you understand the terms herein is contractual and not a mere recital; You have signed this document of your own free act.

Whole Body Vibration Plate Exercise Risks

Whole Body Vibration Plate Machines are scientifically calibrated exercise machines designed to force your muscles to stretch and contract rapidly in small increments, replicating the same action which occurs during traditional exercising, therefore speeding up the needed exercise time. Vibration exercises use your body weight and gravity to its fullest potential. Please do not use a whole body vibration plate or any other exercise device without getting approval from your doctor if you are in the following group: Pregnant women, diabetes with complications such as neuropathy or retinal damage, people with pacemakers, people who have recently undergone surgery, suffer from Epilepsy or Migraines.

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have herniated disks, spondylolisthesis, spondylolysis , have cancer or tumors, people with recent joint replacements, or recently placed IUD's, metal pins or plates, or any other concerns about your physical health. Frail individuals and children should be accompanied by a responsible adult. These contra indications do not mean that you are not able to use a vibration or other exercise device, but we advise you to consult a doctor first.

_____ Initial I understand that using a whole body vibration machine workout is a strictly voluntary physical activity chosen by myself (the patient). If at any time I experience pain or discomfort of any kind, I agree to inform the staff immediately and/or terminate the exercise.

We value your privacy, and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. We do not disclose identifiable information to any third party without your consent. Further, we do not sell, rent, or otherwise allow the unauthorized outside use of personal information such as names, addresses, phone numbers, or e-mail addresses in our database without your permission. Copies of this form and signature will be valid as if original if this document is digitally scanned. If any part of this Release is found to be invalid by the courts having jurisdiction, or becomes inoperative for any reason, such invalidity shall not affect the validity and enforceability of any other provision of this release.

POLICIES AND TERMS AGREEMENTS

Cancellation Policy

We require a 24 hour cancellation notice. Due to demand for treatments, we schedule all appointments following the initial consultation. * If I cancel within 24 hours of a reserved session, I will lose or forfeit my session * If I cancel within 24 hours of a reserved session, I might incur a $35 no-show fee If I fail to show up or am more than 5 minutes late, I will lose or forfeit my session due to staff wages and fees paid for my session, and to avoid inconveniencing other patients scheduled after me. Our cancellation policy has been created to ensure our loyal patients are not disturbed by the tardiness of patients who do not show up on time, or who cancel without a valid reason within 24 hours of an appointment. When reserved sessions are unattended, this means that loyal patients missed the opportunity of having that particular time period. Thank you for your understanding.

I understand the terms herein is contractual and not a mere recital. I have signed this document of my own free act.

Purchase and Reservation Policy

Sessions will only be confirmed and allowed up to the amount of pre-paid sessions. All sales are final and non-refundable. We reserve the right to terminate any patient's session, package, or contract, without refunding any monies, if the patient has broken any terms or policies. All purchases are final, non-refundable and non-transferable.

* I understand if I have purchased and pre-paid for a first-time Customer Promotion, that I may not use or purchase another first-time Promotion without consent. I further state that I am of lawful age and legally competent to sign this aforementioned release. The procedures, alternatives and risks have been explained to me and I have been given the opportunity to ask questions. I understand it is my responsibility to inform the staff if there are any changes to my medical history. I understand the terms herein is contractual and not a mere recital. I have signed this document of my own free act.

I HAVE CAREFULLY READ, UNDERSTOOD AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS.

_____ _____

Patient Date

_____ _____

Management Date

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Treatment Consent Form

Patient	Provider

This consent to treatment form explains the risks and benefits of the Contour Light treatments. Patient understands the following:

1. Results vary greatly from person to person. No result is guaranteed.
2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.
3. Temporary hyper pigmentation/hypo pigmentation (changes in skin color) on rare occasion may occur as a result of treatment.
4. Contour Light should not be used by patients with any of the conditions listed below.

Conditions that Prevent Treatment

Patient agrees (by initialing) that all of the following are true:

_____ I am over the age of 18

_____ I do not have and never had any of the following medical conditions:

- Liver disorder of any kind
- Heart Disease
- Metal Plates/Pins
- Alcohol or Drug Addiction
- Thyroid disorder of any kind
- Cancer (active within 1 year of treatment date)
- Hepatitis C or D
- Kidney disorder of any kind
- Autoimmune Disease
- Serious Mental Disorder
- Gall bladder disorder of any kind
- High blood pressure and high cholesterol
- HIV/AIDS
- Eepilepsy

_____ I am not pregnant or lactating

_____ I do not have any known photo sensitivity to sun exposure

_____ I am not taking any medications that cause photo sensitivity

_____ I do not have a pacemaker

SIGNATURE

By signing below, patient agrees that provider listed above may perform the Contour Light procedure for the purpose of body contouring. Patient understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of patient's knowledge.

Patient Signature _____ Date _____

DISCLOSURE TO THIRD PARTIES (OPTIONAL)

By signing below, patient agrees to permit provider and third parties authorized by provider to use patient's name, photos and/or videos in the marketing of the Contour Light system and procedure. Absent a signature, provider will not disclose patient's identity to any third party except as required by law.

Patient Signature _____ Date _____

Patient Quality Of Life Survey Example

blueprint to Gut Health

PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   - **a.** Medications
   - **b.** Emergency Room
   - **c.** Routine Medical
   - **d.** Exercise
   - **e.** Nutrition/Diet
   - **f.** Holistic Care
   - **g.** Vitamins
   - **h.** Chiropractic
   - **i.** Other (please specify): _____

2. How did the previous method(s) work out for you?
   - **a.** Bad results
   - **b.** Some results
   - **c.** Great results
   - **d.** Nothing changed
   - **e.** Did not get worse
   - **f.** Did not work very long
   - **g.** Still trying
   - **h.** Confused

3. How have others been affected by your health condition?
   - **a.** No one is affected
   - **b.** Haven't noticed any problem
   - **c.** They tell me to do something
   - **d.** People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - **a.** Job
   - **b.** Kids
   - **c.** Future ability
   - **d.** Marriage
   - **e.** Self-esteem
   - **f.** Sleep
   - **g.** Time
   - **h.** Finances
   - **i.** Freedom

5 Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?