PATIENT APPLICATION

GENERAL INFORMATION

Patient Last Name _____ First Name _____

Address _____

Phone (Home) _____ (Cell) _____ Receive Text Messages Y / N

Driver's License # _____ No. Children _____

Email Address _____

Height _____ Weight _____

Sex M F	Married Single Widowed Divorced	Age	Date of Birth	Social Security Number

Full Time Part Time Retired Not Employed

Employer's Name _____

Address _____

Phone _____ Occupation _____

Do you enjoy your work? _____

Favorite Hobbies _____

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 the 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 not to:

_____

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 behaviors. _____

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? _____

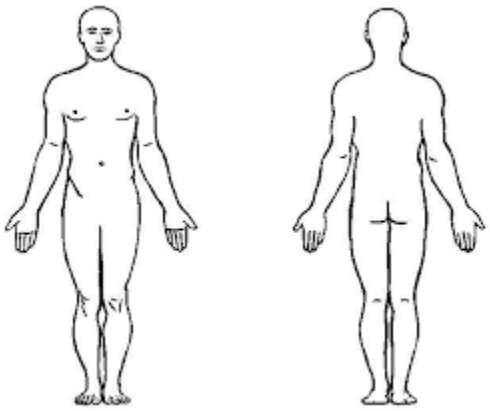
Do you feel your eating behavior is normal? _____

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? _____

Areas of your body you want to change



Contour Light Treatment Disclosure Form

Name:

First_____ Last_____ D.O.B. _____

Program and Background

Your have requested treatment utilizing Contour Light LED light therapy manufactured by Contour research LLC. This treatment is the application of a 635nm light, which has been proven in multiple clinical studies to stimulate the mitochondria of adipose (fat) cells to excerpt 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 medial or cosmetic procedure carries risks, complications, and varied results. The purpose of this document is to inform the patient of the nature of this product and its risk.

Risk / 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
- Cancer active or within 1 year 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
- 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 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 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).

Contour Light

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

_____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 fell I and 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, improvements 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 received 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 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 Mid Ohio Functional Wellness.

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 results 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 exercise 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 age group: Pregnant women, diabetes with complications such as neuropathy or retinal damage, people with pacemakers, people who recently undergone surgery, suffer from epilepsy or migraines.

Contour Light

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

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 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 money, 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, UNDERSTOO AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS

_____ _____

Patient **Date**

_____ _____

Management **Date**

Contour Light 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 or any kind
- Heart disease
- Metal pins/plates
- 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
- Epilepsy

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 patients 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 a third party except as required by law.

Patient Signature_____ Date_____