PREMIER LASER FAT LOSS & CRYO-SCULPTING CENTERS

PATIENT INTAKE PAPERWORK

Home Phone _____ Cell Phone _____
Name _____
Address _____City _____State _____Zip_____
Date of Birth _____/_____/_____ Age _____ **Circle One:** Married Single Other
Height _____ Weight _____
Email address _____

Emergency Contact Information:
Name of Emergency Contact: _____
Phone Number: _____
Relationship: _____

Primary Care Physician Information:
Name of PCP: _____
Name of Practice: _____
Phone Number: _____

How did you hear about our clinic:

Google Search **Facebook** **Instagram** **Yelp** **Internet Search**

Referral **YouTube** **Other:** _____

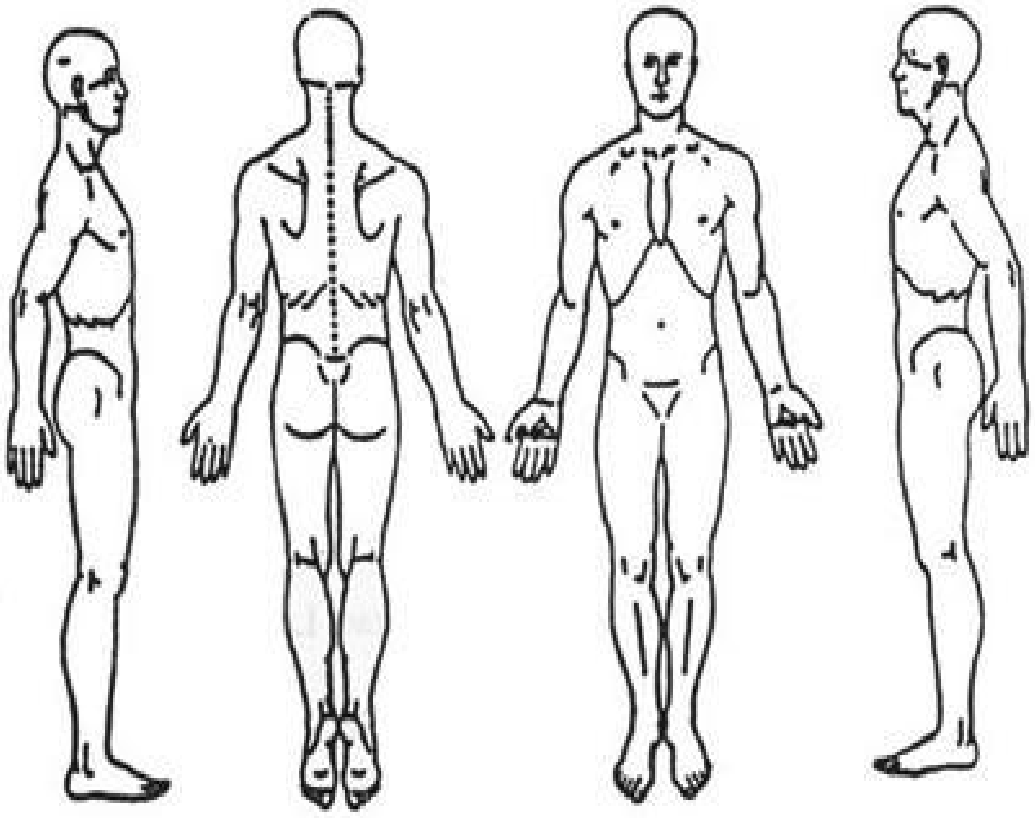
Patient Signature: _____ Date: _____

Body Chart

Patient Name:

Date:

On the body chart below please circle the areas you would like to treat.



Patient Signature: _____ Date: _____

PAST MEDICAL HISTORY:

Please list ALL past surgeries you have had:
Last full physical exam with your PCP:
Have you seen any other medical providers for weight loss?
Do you currently have or have you ever been diagnosed with any type of diabetes, liver disease, seizure disorders or cancer?

MEDICATIONS & ALLERGIES:

Do you have any allergies to medications, latex gloves, ect?
Are you currently taking any pain relievers, muscle relaxers, blood thinners, statin drugs, high blood pressure medications, cholesterol medications, or neurontin/gabapentin?
Please list all current medications:

SOCIAL AND FAMILY HISTORY:

Do you smoke, use recreational drugs, or alcohol?
Do you have a family history of: (circle those that apply) arthritis, diabetes, hypertension, stroke, heart disease, cancer, or any other disease or condition?

EXERCISE:

How many days a week do you get exercise in?
How long do you typically exercise?
What activities do you typically do for exercise?

NUTRITIONAL EVALUATION:

On a scale from 1 to 10 how healthy would you rate yourself?

Describe your typical breakfast:

Do you drink coffee? Yes / NO If Yes, how many cups a day?

Do you drink alcoholic beverages? Yes / NO If yes, how many per week?

Describe your typical lunch:

Describe your typical dinner:

What are your typical snacks:

What is the latest time of evening you eat?

Do you drink milk, if yes how much per week?

Do you eat eggs, if yes how many per week?

Do you drink soda? Yes / No If Yes, how many a week?

How much water do you drink per day?

How many bowel movements do you typically have in a day/week?

How many times do you urinate typically in a day?

How many hours of sleep do you get per evening?

How many hours a week do you work?

What activities do you like to do to relax?

Do you take any supplements for health? If yes, please list:

Patient Signature: _____ Date: _____

All information contained in this packet has been thoroughly reviewed by Physician:
Physician Signature: _____ Date: _____

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operation. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- § Protected health information may be disclosed or used for treatment, payment, or health care operations.
- § The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- § The Practice reserves the right to change the Notice of Privacy Practices.
- § The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- § The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- § The Practice may condition receipt of treatment upon the execution of the Consent.

This consent was signed by: _____

Printed Name-Patient or Representative

_____ ____/____/____

INFORMED CONSENT

Laser Fat Loss, EMSLIM, RF(Radiofrequency), Cryo-Sculpting

I have been informed of potential side effects and risks associated with Laser Treatment for fat loss. These side effects and risks include; increased bowel movements and possible short term elevation of lipids or cholesterol, possible short term soreness of treatment areas. Individuals who are not a candidate for Laser Fat Loss include: diabetic patients that are experiencing neuropathy in the feet or hands, patients with liver disease, and patients with cancer. Research studies have shown that the average fat loss is 3.72 total inches circumference between hips, waist, and thighs, which show patients experiencing more than 3.72 total inches and some less. This treatment has been approved by the FDA for the specific purpose of fat loss. This protocol has been designed to maximize the effectiveness of the therapy and all recommendations should be followed to see the best possible results. Results can not be guaranteed as each patient's physiology, metabolism, and biochemistry are different. Our patient's result and satisfaction is our number one priority. If you are unhappy with your results we will continue to work with you after your treatment plan has concluded to ensure you get the very best results possible.

EMSLIM and RF procedures use high intensity electromagnetic energy to produce muscle contractions while at the same time using radiofrequency to heat the underlying fat or adipose tissue. In some rare cases, skin irritation can occur and in some cases burns on or under the skin can occur. Patients are monitored closely during treatment to maximize the safety of the procedures. By consenting to treatment you understand and are made aware of these potential side effects.
CONTRAINDICATIONS - Metal implants that are not removable. Previous surgeries were mesh implants were placed in the abdomen. Open wounds.

Cryo-sculpting procedures use compressed liquid CO2 that is expelled in a gaseous state at -108 degrees F. The Kaasen unit is equipped with both proximity and thermal sensors and safeguards to prevent frost nip and frost burn to the skin. While extremely safe and effective, cryo-sculpting can cause irritation to the skin and in rare cases frost burn. All precautions are taken to prevent any negative side effects and techniques and providers are extensively trained on the application of the therapy. At any time the procedure feels uncomfortable please inform the technician. Redness is very common after the procedure and will resolve on its own within 24 to 48 hours. By consenting to treatment you understand and are made aware of these potential side effects.
CONTRAINDICATIONS – Localized cryotherapy treatments are very safe for the vast majority of people. However, there are some contraindications, which means treatment should not be provided, including:
Cryoglobulinemia, cold hemagglutinin or cold hemolysis, cold-induced itching, impaired arterial blood flow as from stage II Raynaud's Disease, severe sensory disorders, trophic disorders, hypersensitivity to cold, blood disorders related to coagulation, vasculitis, hypersensitivity to cold, peripheral artery disease, chronic venous insufficiency & post-thrombotic conditions, microvascular dysfunction during diabetes/diabetic foot, skin anesthesia, paraesthesia, polyneuropathy, deficient liver or kidney function, open wounds or broken skin, sunburn, frostbite, Botox or fillers 2 weeks prior, anemia, any other condition where the application of cold vapor may cause harm.

Please inform the staff of any metallic implants including piercings, IUDs, metal shrapnel, medical devices, ect. As this may change the providers treatment recommendations.

Patient Signature: _____ Date: _____

Print Name: _____