Patient Information:

First Name: _____ Last Name: _____ Date: ___/___/___

Gender: _____ D.O.B. ___/___/___ Age: _____ Height: _____ Weight: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone 1: _____ Phone 2: _____ X _____

E-Mail: _____ Occupation: _____

Referred By: _____ Primary Care Physician: _____

Primary Office Phone: _____ Are you currently under a physicians care for any reason? _____

Current Medications and or Over the Counter Drugs: _____

If we have questions related to your treatment(s) do we have permission to contact your physician and discuss your health records?

Circle one: YES NO Signed: _____ Date: ___/___/___

Please indicate your daily consumption of the following: (place a number value that represents the average daily intake)

____ Tobacco ____ Alcohol ____ Caffeinated Beverages ____ Water (8oz glass) _____

Do you exercise? _____ How often and what type? _____

Please place a check next to any of the items below that you currently have or have had a history of:

___ Cancer
___ Infection
___ Skin Rashes / Skin Disorders
___ Inflammation
___ Blood Thinners
___ Circulatory / Heart Conditions
___ Phlebitis / Blood Disorders
___ Broken Bones
___ Diabetes / Endocrine Disorders
___ Recent Injury or Trauma
___ Hepatitis
___ HIV / AIDS
___ Varicose / Spider Veins
___ High / Low Blood Pressure
___ Stroke
___ Recent Surgery
___ Scars
___ Acute Joint / Muscle Injury
___ Fibromyalgia
___ Implants / Prosthetics
___ Sprains / Strains
___ Epilepsy / Seizures
___ Abdominal / Inguinal Hernia
___ Cosmetic Procedures
___ Headache
___ Back Pain
___ Open Cuts / Bruises / Burns
___ Lipoma / Angioma
___ Dizziness
___ Corticosteroid Treatments
___ Piercings
___ Raised Moles
___ Vitiligo

If you checked any of the items above please explain in detail: _____

_____

Are you pregnant or planning a pregnancy in the next 3 months? _____ Are you using hormonal contraception? _____

Are you undergoing hormone replacement therapy (HRT)? _____ Are you perimenopausal or menopausal? _____

These questions specifically apply to the face. Please place a check next to any of the items below that you currently have or have a history of:

___ Broken Facial Capillaries
___ Cystic Acne
___ Active Herpes
___ Russian Threads
___ Facial Sores or Eruptions
___ Dermatitis (rosacea, eczema, psoriasis, etc.)

In the last six months have you had:

___ Facial Surgery ___ Chemical Peel ___ Laser Treatment ___ Facial Injections or fillers

Information I have provided is true and correct to the best of my knowledge. I have stated all medical conditions I am aware of and will inform my practitioner of any changes in my health status.

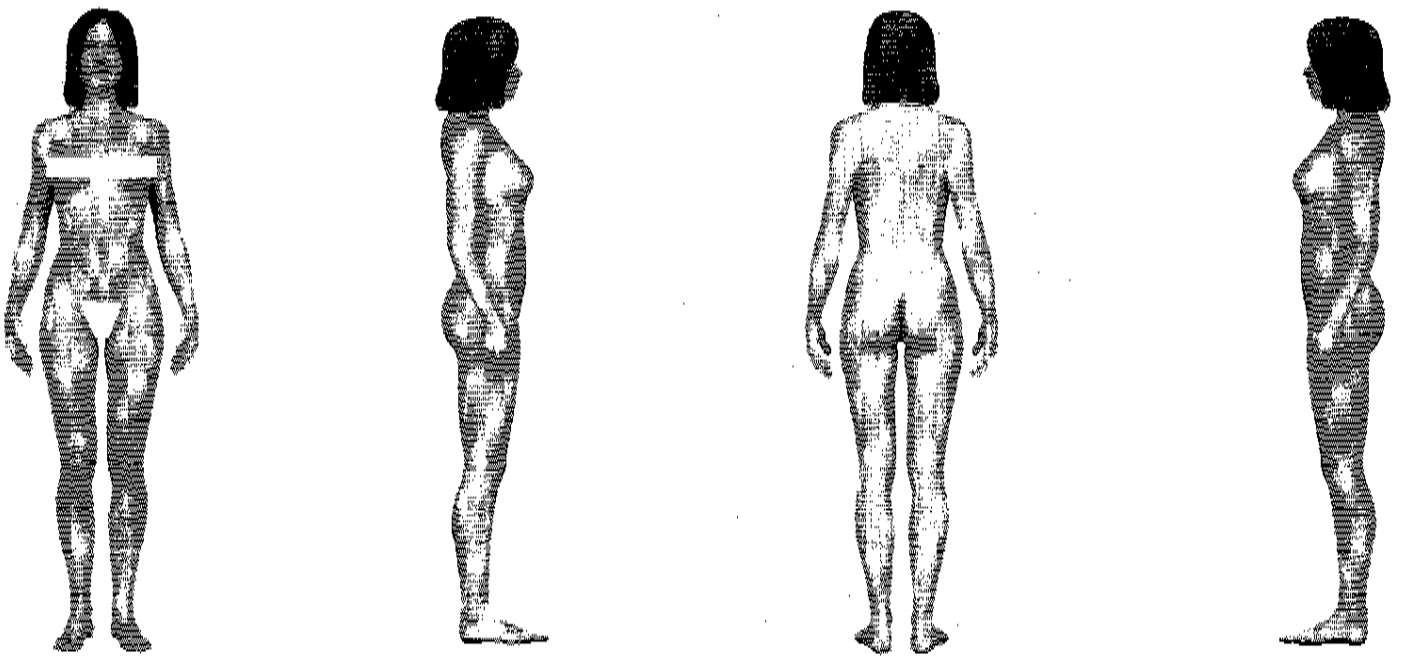
ed _____ Name _____ Date ____/____/____

ent Evaluation: (THIS SECTION IS TO BE FILLED OUT BY THE PRACTITIONER)

Type: ___ Gynoid ___ Android ___ Mixed

down your observations of the patient directly on the figures below. In addition to the legend below please take care in noting areas should be avoided during treatment.

ANTERIOR **RIGHT PROFILE** **POSTERIOR** **LEFT PROFILE**



(C) CELLULITE **(P)** PROBLEM AREAS **(L)** LOOSE SKIN **(V)** VARICOSE VEINS **(S)** SPIDER VEINS

Skin Condition	Date ____/____/____ Session #	Date ____/____/____ Session #	Date ____/____/____ Session #	Date ____/____/____ Session #
wollen Skin Y / N				
ose Skin Y / N				
cal Fat Pockets Y / N				
ellulite Stage* [0 to 3]				

= NO CELLULITE, 1= SUBCUTANEOUS FAT DURING PINCH TEST, 2= CELLULITE STANDING, DISAPPEARS WHEN LYING, 3= CELLULITE STANDING AND WHEN LYING

down your observations of the patient directly on the figures below. In addition to the legend below please take care in noting areas should be avoided during treatment.

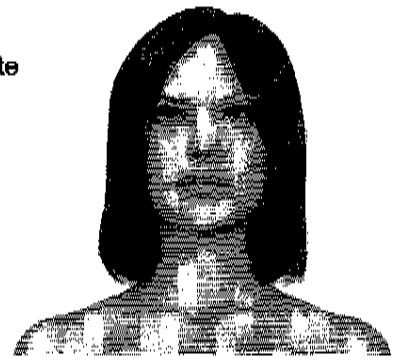
Crows feet ___ Double chin ___ Wrinkled or loose decollete

Facial Swelling ___ Swollen eye tissue

Neck lines ___ Loose facial skin (mark location)

Lip lines ___ Facial wrinkles (mark location)

Loose jaw line skin ___ Dull, devitalized skin



Endermologie By Debbie Client Consent and Authorization

INFORMED CONSENT: I hereby authorize the administration of Endermologie treatments.

The nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been explained to my satisfaction.

PHOTOGRAPHS: I give permission for my photographs to be used to help document my treatment course.
_____By initialing here I authorize the use of my before and after photos for marketing and understand I will receive a free gift if they are used.

No guarantee, warranty or assurance as been made to me as to the results that may be obtained. I am aware that multiple treatments are necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. NO REFUNDS WILL BE GIVEN FOR TREATMENTS RECEIVED. NO REFUNDS WILL BE GIVEN ONCE A PACKAGE HAS BEEN STARTED. I understand and agree that all services rendered to me are charged directly to to me and I am personally responsible for payment.

I release Debra McCaslin and her office staff and technicians from liability associated with this procedure. I certify that I am competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, and successors.

My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice.

PATIENT'S SIGNATURE: _____DATE_____

APPOINTMENT POLICY FOR ENDERMOLOGIE, FACE LIFT, AND ALL OTHER ANTI-AGING SERVICES BY DEBBIE

In order to create a positive experience for all, I understand that some of our clients have time limitations, and as such, I do my best to accommodate everyone's treatment schedule by running on time.

In this regard, as a courtesy to others, it is very important that **you** arrive **on time** for your scheduled appointment.

If you do arrive late for your appointment and someone is scheduled right after you (which is normally the case), in fairness to the next client, your appointment will be cut short by the amount of time I need to start the next person on time and the regular charge for your session will apply.

Due to the fact that my schedule is extremely busy and at times there is a waiting list for people trying to get scheduled, I require a 24 hr. notice if you are going to cancel an appointment so that I can find someone else to fill your appointment time. Without that notice, I am losing my income and you are preventing someone else from being able to receive treatment that they could have otherwise gotten. As such by your signature below you recognize and agree to the fact that without a 24 hr. notice, except in an emergency situation, you will be charged for your appointment.

Thank you for your cooperation and understanding in this matter.

Sincerely,

Debbie McCaslin

Client's Name (Printed)_____

Client's Signature_____

Date_____