HEALTH HISTORY

Name: ____ Date: ________________

Cell #: _________________ Home #: _________________ Email: _____________________________

Address: ____

City: ____ State: ________ Zip: ____________

Emergency Contact: _________________________________ Phone: ________________________

Relationship: Spouse Parent Friend Other_____________________

History: Please indicate if you have experienced or are experiencing any of the following conditions.

- ☐ Abdominal Pain / Bleeding
- ☐ Abdominoplasty
- ☐ Cancer (active within last 5 years) If so, list diagnosis and remission dates________________________
- ☐ Cardiac Surgery - if yes, please list type(s) and date(s) _________________________________
- ☐ Cardiovascular Disease
- ☐ Celiac Disease
- ☐ Chest Tightness / Left Shoulder or Arm Pain
- ☐ Congenital Anomaly - if yes, please describe ____
- ☐ Congestive Heart Failure
- ☐ Congestive Obstructive Pulmonary Disease (COPD)
- ☐ Cosmetic Surgery - if yes, please list procedure(s) and date(s) ____________________________
- ☐ Diabetes: Type 1 ____ Type 2____ Prediabetes _____ Gestational ______
- ☐ Diarrhea / Constipation
- ☐ Gastric Bypass / LAP-BAND Surgery
- ☐ Gastro-Intestinal Issues
- ☐ Heart Palpitations
- ☐ Implanted Medical Device – if yes, which ____
- ☐ Infection (active currently)
- ☐ Insulin dependent
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Disease / Gall Bladder issues
- ☐ Liposuction - if yes, please list area(s) treated and date(s) _________________________________
- ☐ Liver Disease
- ☐ Pregnant or Breast Feeding

- ☐ Stomach Stapling
- ☐ Thyroid Issues

Please list **ANY** medical conditions you have that are not mentioned above:

____

____

Which medications are you currently taking?

____

____

Lifestyle: Please indicate your level of the following:

Alcohol intake:	None	Light	Medium	Heavy
Appetite:	None	Light	Medium	Heavy
Coffee:	None	Light	Medium	Heavy
Exercise:	None	Light	Medium	Heavy
Recreational Drugs:	None	Light	Medium	Heavy
Tobacco:	None	Light	Medium	Heavy
Sleep:	None	Light	Medium	Heavy
Soft Drinks:	None	Light	Medium	Heavy
Water:	None	Light	Medium	Heavy

Acknowledgement: *I certify that the preceding medical and personal history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical and health condition. A current medical history is essential for the caregiver to execute the appropriate treatment procedures.*

____ ____________________

Patient Signature Date

____ ____________________

Witness Date

ZERONA™ Low Level Laser Therapy Consent Form

A. Program and Background

You have requested to be treated with the ZERONA™ low-level laser therapy manufactured by Erchonia Medical®. This treatment is the application of a 635nm low intensity laser, which has been shown through extensive research to cause the fat within the adipocyte (fat cell) to leave the cell and accumulate in the interstitial space around the cells. In contrast to high-power, high heat lasers that are used in various medical procedures, the low level laser used for this treatment has no thermal effect on tissue. Instead, the non-invasive laser helps the body absorb fat by stimulating its biological function. Excess fat is then removed naturally by the body's lymphatic system and subsequently excreted without the negative side effects and downtime associated with more invasive procedures such as liposuction. This therapy has been tested in several institutional review board approved studies in a double blind; placebo controlled fashion and found to be generally effective. Any medical or cosmetic procedure carries risk, complications and varied results as to the effectiveness of a particular treatment. The purpose of this document is to make you aware of the nature of this product and its risks in advanced so that you can decide whether to go forward with this procedure.

Non-invasive low level laser assisted therapy has been approved by the FDA when used in conjunction with liposuction. This treatment, when used without liposuction, is currently considered an "off label" use of the device. The data from these studies is pending FDA approval.

B. Procedure

Initially you will consult with the doctor to determine if you are a candidate for low level laser therapy. During this time period you will have the opportunity to ask questions or voice concerns you may have concerning this treatment. If it is determined you are a candidate for this procedure, there will be a few preliminary steps consisting of: paperwork, measurements, and photos. Proceeding, the patient will need to change into a hospital gown and will lie down. From here the treatment will be administered by aiming the ZERONA™ five 635nm low level laser heads on the desired area(s) to be treated. There are some other options available to patients; however for body contouring the patient will be treated for twenty minutes on the front of the desired area to be treated. Once this initial twenty minute period has expired, the patient will then turn over and the back of the desired area will be treated for another twenty minutes. It is recommended that a patient will need a minimum of six treatments for the low level laser to achieve its potential effect.

This treatment should be used in conjunction with a healthy diet, exercise, and the use of Niacin (Vitamin B3). If you are not currently exercising you should consult a health care professional before beginning an exercise program to determine if your body is physically able. The use of Niacin (Vitamin B3) is recommended in conjunction with this treatment. The doctor will review your medical history to determine if the use of Niacin is right for you. Niacin is used to assist your body in removing the fat from your blood stream. Niacin has been known to reduce LDL-cholesterol, reduce triglycerides, and increase HDL-cholesterol.

C. Risks/Discomfort

There are few risks associated with low-level laser therapy. This treatment is non-invasive and uses a cold output laser. During treatment no discomfort will be present, the patient will not feel the laser, however the light will be visible. The only discomfort that may occur is if a patient is

taking Niacin. Niacin is a vasodilator, and a naturally occurring flush can cause the upper extremities, face, neck, and ears to become red and itch. The only known or anticipated risk with the use of the laser device is that long-term exposure to laser light could cause damage to eyesight. You will be provided with protective eyewear and to avoid this risk, you must wear them throughout the course of your treatment.

***Please inform us if you think you are pregnant, or are unsure if you may be pregnant, as a pregnancy test may be required to proceed with treatment. Although no known detrimental risks exist, potential unknown risks may exist.**

If you have a pacemaker, this treatment may not be right for you. It is recommended that one does not treat directly over a pacemaker or its lead wires. No known risks exist, however potential unknown risks may exist. There are also a variety of other conditions for this treatment.

It is possible that you may not see any improvement in your body shape or it may get worse. There also may be unknown risks associated with low-level laser therapy.

D. Benefits

Over the years the benefits of low-level laser therapy have become more prominent. Low-level laser therapy has been used by chiropractors for pain management and recently by cosmetic surgeons to emulsify adipose 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 3.5 inches lost from there stomach, hips, and thighs. These results do vary and no guarantee is implied or suggested that desired results will be achieved.

E. Alternatives

This is strictly voluntary cosmetic procedure. No treatment is necessary or required. Alternative treatments, which vary in sensitivity, effect, duration, and invasiveness including: liposuction, mesotherapy, lipodissolve, velasmooth, dieting, exercise and potential others; which may have their own risks and benefits. You acknowledge this, and realize that the other option to you is do nothing.

F. Questions

By signing below, you certify that this procedure has been explained to you and your satisfaction. Any further questions can be directed to Dr. Karen Tedeschi, Tedeschi Wellness.

G. Satisfaction Guarantee

The Wellness Studio guarantees satisfaction for the ZERONA™ low-level laser therapy and will extend treatment protocol until desired results, or minimum inch loss as reported in FDA trials, is reached.

H. Consent
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 The Wellness Studio to perform the described treatment or administer any related treatment as deemed necessary or advisable for my medical condition.

The purpose of this procedure, risks, complications, alternative methods of treatment have been fully explained to my satisfaction. I understand the distinction between "on label" and "off label" use of Erchonia's ZERONA™ low-level laser therapy. No guarantee has been given by anyone 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 herby give my consent to have this procedure.

PHYSICIAN ATTESTATION
I have explained the procedure, alternatives, and risks to the person or persons whose signature is affixed below. The patient has verbally communicated to me that they understand the contents of this form.

______________________________ ____________________
Signature of Physician Date

PATIENT CERTIFICATION
By signing below I state that I am 18 years of age or older, or otherwise have authorized to consent. I have read or have had explained to me the contents of this form. I understand the information on this form and give my consent to what has been explained to me.

______________________________ ____________________
Signature of Patient Date

INTERPRETER ATTESTATION (When Applicable) I have provided translation to the person(s) whose signature(s) are affixed above.

______________________________ ____________________
Signature Date

Cancellation/Rescheduling & Payment Policy

Payment: Payment in full is required on or before day of initial treatment. The following payment options are available:

Cash or Check: You may pay for your treatment with Cash, Check or Cashier's Check. All returned checks will be assessed a return check charge of $30.00 each time a check is returned, regardless of the reason.

Credit Cards: We accept Visa, MasterCard, American Express and Discover.

GreenSky: Medical finance program approved for our practice.

Punctuality: Please arrive 15 minutes early so you can be well-prepped and enjoy an unhurried transition into your treatment.

Arriving Late: Arriving late will interfere with your treatment, therefore, making the treatment time needed insufficient. Your treatment will end at your scheduled time not to interfere with the next appointment.

No show: We strongly encourage you to communicate with us. If you fail to arrive for your scheduled treatment time without having notified us, you will be subject to lose your deposit or future appointments. A no show will also disengage or void any agreements you may have with our office.

Cancellation: We take pride in the appropriate reservation of your procedural date and scheduled time. Our priority is to schedule procedures that can be attended to with the utmost of care. Our office scheduling policy is very time sensitive due to constraints of the procedure. Therefore, please understand the importance of respecting our one week cancellation/reschedule policy.

Our one week cancellation/reschedule policy is very strict. If you fail to reschedule your appointment one week prior to initial appointment, cancel or do not show, you are subject to lose your future appointments and or deposit / unused money.

Cancellaton 8 or more days prior to your scheduled appointment date: will result in 5% loss of all fess to cover Credit Card charges.

Cancellation 4-7 days prior to your scheduled appointment date: will result in a 25% loss of all fees.

Cancellation on the day of, or less than 72 hours prior to your scheduled appointment date will result in a 50% loss of all fees.

No refunds after initial treatment.

____
Patient Name

____ ________________
Patient Signature Date

____ ________________
Witness Date

7939 E Arapahoe Rd, Suite210
Greenwood Village, CO 80112
☎ 303.220.1100

1001 W 120th Ave, Suite 130
Westminster, CO 80234
☎ 303.466.0100

Privacy Notice and Authorization

As you are no doubt aware, major changes in Federal privacy requirements – the HIPAA privacy regulations obligate most physician practices to provide notice about privacy rights and detailed policies designed to protect your privacy. These requirements were put into place because increased patient information is being shared in digital format over computer networks.

MD Body & Med Spa is committed to protecting patient confidentiality. You should understand the following with regard how we treat your personal health information.

1) When you register as a new patient, you will be asked to sign an authorization, also provided below, that includes a release of information that allows us to request and obtain records from practitioners that you have seen for the purpose of assisting us in your treatment. If you desire records to be sent to a health provider you have not yet seen, a family member, an attorney, or other party outside of this list, you must first sign a release of information before we can forward your information. You may be subject to fees.

2) We cannot release information to family members, other than parents or legal guardians, even if they are involved in your care, without your written permission.

3) In order to assure quality of care, MD Body & Med Spa records are occasionally reviewed both internally and by outside consultants in legal, clinical, and other concerns that affect the quality of services we provide. Only necessary information is accessed, and any such review is by a professional staff working under the condition of confidentiality.

4) If you wish to limit the nature of information that is released, or the parties noted above to whom information may be provided, please ask to meet with a MD Body & Med Spa privacy coordinator to discuss limitations. In some instances, MD Body & Med Spa may not be in a legal position to honor requested limitations.

5) We may be required by law, in some cases, to make disclosure of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies of the US Department of Health and Human Services.

6) Because MD Body & Med Spa is subject to HIPAA, MD Body & Med Spa practices long established and useful business practices, such as providing you with appointment reminders, notifying you of lab results, or using sign-up sheets, but we will take steps to do so in a fashion that takes your privacy expectations into account. Please inform staff of any limitations you would like us to honor in this regard.

7) MD Body & Med Spa reserves the right to charge for copying and forwarding your health records.

8) While the records of the care we provide are MD Body & Med Spa property, we will make them available for your inspection and provide copies at a reasonable fee. If you have any concerns about your health records, please ask to speak with a MD Body & Med Spa Medical Staff member.

9) I have been offered the patient right to review the Complete HIPAA compliance document and understand that MD Body & Med Spa will comply to protect my privacy.

Please acknowledge review of this notice and authorization of this release of medical information by signing below.

______________________________ ________________________

Patient Signature Date

______________________________ ________________________

Witness Date