ABSOLUTE SCULPT INFORMATION AND CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

This form is designed to give you the information you require to make an informed decision to undergo treatment. If you have any questions before the treatment, please feel free to ask.

I __________________________ have received the following information about the Absolute Sculpt
Printed Name

You are scheduled for a series of non-invasive treatments with the Absolute Sculpt. The device is indicated for the improvement of tone and strengthening of abdominal, buttock, leg and arm muscles.

Your treatment provider will discuss your specific treatment needs. The recommended number of treatments is 8. The treatment is typically about 30 minutes per session, with sessions separated by at least 2 days. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on your condition.

Before the treatment, you are not required to do anything special. On the day of the treatment, you are advised to wear comfortable clothing, allowing flexibility for correct positioning during the treatment. You will be asked to remove all jewelry and electronic devices.

I acknowledge that a successful treatment outcome can be affected by smoking or excessive alcohol consumption. While no special diet is required, you are encouraged to eat healthily to help promote and maintain results.

There is typically no pain associated with your treatment, and there is no anesthetic required. During the application, you will feel intense yet not painful contractions in the treated area. The procedure doesn't require any recovery time. Typically, you can get back to your daily routine right after the treatment.

Please answer whether you currently have or have had any of the following:

- ☐ Metal or electronic implants
- ☐ Cardiac pacemakers, implanted defibrillators, implanted neurostimulators.
- ☐ Drug pumps ☐ Pulmonary insufficiency ☐ Malignant tumor
- ☐ Fever ☐ Allergy to latex ☐ Hemorrhagic conditions
- ☐ Anticoagulation therapy ☐ Heart disorders
- ☐ Epilepsy recent surgical procedures (muscle contraction may disrupt the healing)
- ☐ Areas of the skin which lack normal sensation

Have you been pregnant?	☐ YES	☐ NO
C-section?	☐ YES	☐ NO
Vaginal birth?	☐ YES	☐ NO
Are you satisfied with the strength of your core muscles?	☐ YES	☐ NO
Are you satisfied with the shape of your buttock?	☐ YES	☐ NO

Other conditions and allergies:

____

PH: 9389 9099 | F: 9389 9390 | reception@absolutecosmetic.com.au | www.absolutecosmetic.com.au
Image 21, Suite 2, 21 Stirling Highway, Nedlands, WA 6009

ABSOLUTE SCULPT INFORMATION AND CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

This form is designed to give you the information you require to make an informed decision to undergo treatment. If you have any questions before the treatment, please feel free to ask.

I am aware that the treatment can't be applied over the head and heart.

I am aware that pregnancy and nursing are contraindicated, and pregnant women cannot undergo the treatment.

I understand that there are certain risks associated with HIEMT treatments. They include but are not limited to muscular pain, temporary muscle spasm, temporary joint or tendon pain, and local erythema or skin redness.

I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks.

I agree to before and after treatment photographs, measurements, and weighing, as this will help for medical evaluation of the treatment results. Information will be acquired for medical records.

I understand the results may vary from person to person and that an exact result cannot be predicted. Completing a full treatment series is necessary to maximize treatment efficacy. It is very unlikely, but it is possible that you will not feel any recognizable result after the procedure.

I acknowledge the results may not meet my expectations.

I certify that I have read this entire document and that I agree with all provisions.

I certify that I have had the opportunity to ask questions. These questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure, and possible side effects.

I have read the above information, and I request and consent to be treated with the HIEMT by the service provider in this practice and their designated staff.

My signature below indicates that the above information is accurate and current.

Any questions I may have asked, have been answered to my satisfaction.

________________________________ ________________

Patient Signature *Date*

________________________________ ________________

Witness Signature *Date*

I cannot dispute what I have read, agreed to and signed above. If I do then I agree to pay all costs incurred by ACM if I breach this agreement. I agree to follow the ACM Social Media Policy and pay all costs incurred by ACM if I breach this policy. I Understand that photographs are for clinical use only. I am responsible for taking myy own photographs for my records.

____

Patient Initial

PH: 9389 9099 | F: 9389 9390 | reception@absolutecosmetic.com.au | www.absolutecosmetic.com.au
Image 21, Suite 2, 21 Stirling Highway, Nedlands, WA 6009