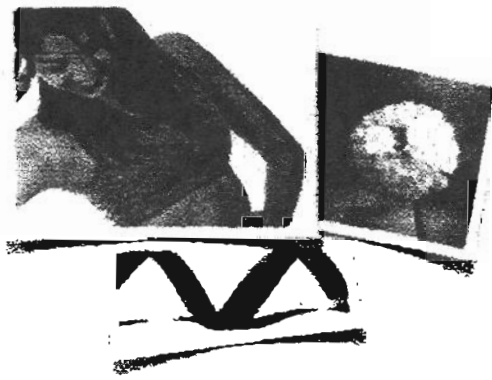


Contour Light



Consent and Release of Liability Form Informed Consent Release and Indemnity Agreement

Name:

(First) _____

(Last) _____ DOB _____

Program and Background

You have requested treatment utilizing Contour Light LED light therapy manufactured Contour Light LLC. This treatment is the application of a 635 nm light, which causes fat within the adipose (fat) cell to leave cell and accumulate in the cells interstitial space, utilizing stimulating of it's biological function to help the body break down fat. This excess fat is moved by the body's lymphatic system and excreted without negative side effects or downtime. Any medical or cosmetic procedure carries risks, complications and varied results. The purpose of this document is to inform of the nature of this product and it's risk. LED therapies have been approved by the FDA.

Procedure

Initially you will consult with a Contour Light therapist to determine if you are a candidate for the LED therapy. You will have the opportunity to ask questions or voice concerns you may have regarding this treatment. If it is determined you are a candidate for this procedure, then paperwork, measurements, pre and post treatment photos (upon your approval) and suggested course of treatment will be given. The treatment is administered by placing up to 4LED pads on the desired area(s) to be treated. It is recommended that a patient will need a minimum of 9 - 12 treatments for the Light LED therapy to achieve its desired effect. This treatment should be used in conjunction with a healthy diet and exercise. You should consult a health care professional before beginning any new exercise program to determine if your body is physically able.



Risks/Discomfort

This treatment is non-invasive. During treatment there should be no discomfort, the client will feel the warmth of the light and the tightness of the bands holding the paddles. Contour Light is suitable for anyone over 18. Anyone suffering from the following would not be suitable for this treatment, pregnant, breast feeding, kidney or liver disease, cancer, heart disease, heart/pacemaker, autoimmune disease, metal pins/plates, thyroid problems or urine infection

Benefits

LED Light therapy has become more prominent and has been used in many studies 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 2-5cm lost from there stomach, hips, and thighs. These results do vary and no guarantee is 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 client).

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

_____ **Initial** I understand that a minimum of 9 - 12 treatments is required to achieve full results at an average BMI of 25 to 30. A BMI of over 30 (which is considered in the obese range) requires a specific strategy moving forward with the minimum recommendation of 24 + treatments. At that point, I will be re-evaluated to see if more sessions are needed in order to achieve

realistic goals. Each body is different and may require more or less treatments depending on the clients diet, exercise, metabolism and body type. I understand the

treatment is most successful if I also maintain a healthy diet and commit to an exercise program.

_____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 feel I am 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, improvement 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 reviewed this consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form I grant authority us to perform the described treatment. 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 not 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 clients progress and may be used in marketing ads.

Questions and Explanations

By signing below, you certify that this procedure has been explained to you and 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 result 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 exercises use your body weight and gravity to it's 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 group: Pregnant women, diabetes with complications such as neuropathy or retinal damage, people with pacemakers, people who have recently undergone surgery, suffer from Epilepsy or Migraines, have herniated disks, spondylolisthesis, spondylolysis, have cancer or tumors, people with recent joint replacements, or recently paced UID's, metal pins or plates, or any other concerns about your physical health. Frail individuals and children should be accompanied by a responsible adult. These contra indications do not mean that you are not able to use a vibration or other exercise device, but we advise you to consult a doctor first.

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

We value your privacy, and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. We do not disclose identifiable information to any third party without your consent. Further, we do not sell, rent, or otherwise allow the unauthorized outside use of personal information such as names, addresses, phone numbers, or e-mail addresses in our database without your permission. Copies of this form and signature will be valid as if original if this document is digitally scanned. If any part of this Release is found to be invalid by the courts having jurisdiction, or becomes inoperative for any reason, such

invalidity shall not affect the validity and enforceability of any other provision of this release.

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 clients scheduled after me.

Our cancellation policy has been created to ensure our loyal clients are not disturbed by the tardiness of clients 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 clients missed the opportunity of having that particular time period. Thank you for your understanding.

understand the terms herein is contractual and not a mere recital. I have signed this document of my own free act.

Our cancellation policy has been created to ensure our loyal clients are not disturbed by the tardiness of clients 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 clients missed the opportunity of having that particular time period. Thank you for your understanding.

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 client's session, package, or contract, without refunding any monies, if the client 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, UNDERSTOOD AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS.

_____	_____
Client	Date
_____	_____
Management	Date

PATIENT NAME:



ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

		(Date)
PATIENT SIGNATURE	X	
(Or Patient Representative)		(Indicate relationship if signing for patient)
		(Date)
OFFICE SIGNATURE	X	

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

NCC-CA

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME:

PATIENT SIGNATURE X (Date)

(Or Patient Guardian/Parent/Representative) (Provide name and relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE