VACUUM TREATMENT CONSENT FORM

Patient Name ____________

The Zemits Vacuum Treatment is a non-invasive treatment. It uses vacuum applicator to draw in skin tissue The procedure is for improving the appearance of cellulite and reducing circumferences and that it may also be therapeutic for improving circulation and muscle aches in the treated areas. It is not a weight-loss solution and it does not replace traditional methods such as liposuction.
Initial:

I duly authorize _____________________ to perform Zemits Vacuum Treatment on me.

I understand that:
The Zemits is a device used for improving the appearance of cellulite and reducing circumferences and that it may also be therapeutic for improving circulation and muscle aches in the treated areas. I understand there is a possibility of short-term effects such as discomfort, reddening, temporary bruising and temporary discoloration of the skin as well as rare side effects, just as scarring and permanent discoloration.
These effects have been fully explained to me. ________ (patient initials)

I understand that:
The suction pressure may cause sensations of deep pulling, tugging and pinching. You may experience intense stinging, tingling, aching or cramping as the treatment begins.
These effects have been fully explained to me. ________ (patient initials)

I understand that:
Clinical results may vary depending on individual factors, including but not limited to the medicial history, skin type patient compliance with pre- and post-treatment instructions, and individual response to treatment.
These effects have been fully explained to me. ________ (patient initials)

I understand that:
Bruising, swelling, and tenderness can occur in the treated area and it may appear red for a few hours after the treatment.
These effects have been fully explained to me. ________ (patient initials)

I understand that:
Treatment with the Zemits involves a series of treatments and the fee structure has been fully explained to me.
_______ (patient initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I have informed _________________________ regarding any current or past medical condition, disease or medication taken.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the context of this consent form.

Do you have any of the following?

- Impaired peripheral circulation in the area to be treated Yes / No
- Neuropathic disorders such as post-herpetic neuralgia or diabetic neuropathy Yes / No Impaired skin sensation Yes / No
- Open or infected wounds Yes / No
- Bleeding disorders or concomitant use of blood thinners Yes / No
- Recent surgery or scar tissue in the area to be treated Yes / No
- A hernia or history of hernia in the area to be treated Yes / No
- Skin conditions such as eczema, dermatitis, or rashes Yes / No
- Pregnancy or lactation Yes / No
- Infection in the urinary system i.e. kidneys, bladder and urethra Yes / No
- Crohn's Disease Yes / No
- Hyperthyroidism Yes / No
- Deep Venous Thrombosis Yes / No
- Lymphedema Yes / No

Contraindications

1. Diabetes– the body's inability or lowered abilityto regulate blood sugar and fat levels can significantly hinder the proper removal of fat cell contents from the lymphatic system, thus lowering the overall effectiveness of the treatments
2. Thyroid problems– thyroid regulates overall metabolismof the body, thus it can deter the proper disposal of fat contents from the body, and hence also lower the overall effectiveness of the treatments
3. Current or history of skin cancer or pre-malignant moles– In order to avoid and prevent any further irritation to these conditions treatment of body areas with these conditions should not be performed. We recommend you talk with your physician before committing to any treatment.
4. Any active skin conditions– It is best to scheduletreatment when any skin conditions in treatment areas such as sores, psoriasis, eczema, herpes and rashes are no longer active to avoid and prevent any further irritation of skin. 5. Alcohol and Caffeine– These substances will slow downlymphatic drainage of fatty acids and toxins. For best results, please try to avoid or reduce your intake of products that contain them during the course of treatment. Infection in the urinary system i.e. kidneys, bladder and urethra.

- Crohn's Disease Hyperthyroidism
- Deep
- Venous Thrombosis
- Lymphedema

I acknowledge the following:

- I understand and acknowledge that vacuum therapy is performed by suction at certain points on the body in attempt to treat buttocks enhancement, slimming, detox, anti-cellulite, pain management, and to stimulate lymphatic drainage. I am aware and acknowledge that certain adverse side effects may result.
- I understand there are no guarantees regarding its use and effects and that I am free to stop the vacuum treatment at any time.
- I understand that vacuum therapy does commonly leave marks on the skin that vary in pattern and colour (from light to dark purple) and usually lasts 3 days to a week, and sometimes longer.
- I will inform the laser technician, nurse or physician if my medical condition changes over the course of treatment.
- By signing below, I certify that I have been given the opportunity to ask questions and that I have read and fully understand the context of this consent form.

Print name: _________
Signature: __________
Date: _____________