

# Lipo-Light Body Sculpting Treatments

## Welcome and Congratulations!

You have made an important decision towards improving your wellness, vitality and overall lifestyle! We at Achievement Chiropractic share the mutual desire of you reaching all of your wellness goals involving the Lipo-Light body sculpting treatments.

In order for you to reach these goals, we have provided a few tips to help you maximize your results. It is important to manage your expectations according to an appropriate diet, lifestyle and exercise program in conjunction with your Lipo-Light treatment protocol.

## TO ENSURE YOUR BEST RESULTS:

- ✓ **Keep Your Scheduled Appointments!**  
Appointments missed canceled or rescheduled with less than 24 hours notice will be forfeited. Late arrivals of more than 5 minutes may also result in a forfeited session.
- ✓ **Drink Plenty of Water Before and After Each Treatment**  
(consume at least ½ your body weight in ounces of water daily)
- ✓ **Avoid ALL Alcohol and High Sugar Content Drinks (Including Sports Drinks.)**
- ✓ **Do Not Eat 2 Hours Before and After Each Treatment!**
- ✓ **Do NOT Eat White Refined Carby Foods (Rice, Bread, Pasta, etc), and Avoid Fried Food!**
- ✓ **Incorporate Aerobic Exercise Post Treatment for 30 Minutes**
- ✓ **Manage Caloric Intake; Excess Calories Will Counteract Treatments**
- ✓ **Limit Use of Sweeteners (Natural and Artificial)**
- ✓ **Eat More Raw Produce (7-9 Servings of Fruits and Vegetables Each Day)**
- ✓ **Get Plenty of Sleep!**

**Thank You!**

***Your success is our #1 priority!***

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Desired Weight \_\_\_\_\_ Age \_\_\_\_\_

Marital Status \_\_\_\_\_ Occupation \_\_\_\_\_ Hobbies \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ If by referral, who can we thank? \_\_\_\_\_

What one area would you like to see change the most? \_\_\_\_\_

What do you expect from your Lipo-Light treatments? \_\_\_\_\_

How long have you wanted to lose weight/inches? \_\_\_\_\_ How much weight/inches do you

want to lose? \_\_\_\_\_

Why is this important to you? \_\_\_\_\_

Does your weight problem make you physically and/or emotionally uncomfortable? (explain) \_\_\_\_\_

On a scale of 1 to 10 with 10 being **MOST** committed, how committed are you to taking action and making a change in your life today?

1 2 3 4 5 6 7 8 9 10

**Thank you and we look forward to helping you achieve success!**

Measurement (for technician) Location: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_  
Pre: \_\_\_\_\_ Post: \_\_\_\_\_

# Lipo-Light Body Sculpting Treatments

## Contraindications

Thank you for your interest in our Lipo Light Body Sculpting treatments.

It is not recommended for you to proceed with any Lipo-Light treatments under the following conditions:

- Under the age of 18
- Pregnant or breastfeeding
- Medically morbidly obese
- Epilepsy
- Pacemaker or other metal implants
- Active herpes simplex (genital herpes)
- Uncontrolled hypertension
- Liver or kidney disorders
- Thyroid gland dysfunction
- Compromised immune system
- Cancer or history of cancer (at least 10 years with no recurrence)
- Photo sensitivity to sun exposure
- Taking drugs that cause photo sensitivity

I understand it is my personal responsibility to inform the staff of Achievement Chiropractic of any changes to my medical history during the course of treatment and I confirm that I shall advise Achievement Chiropractic of any changes.

I authorize the technicians of Achievement Chiropractic to perform the Lipo-Light treatments. I am aware that clinic results may vary depending on individual factors, including medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. I have been made aware that my diet and the amount of exercise I do will have a major effect on the results of my treatments. If I do not make an effort to address my dietary requirements and exercise, I am aware that the results achieved may not be retained.

---

Patient Signature

---

Date

**Achievement Chiropractic/Lipo Light Chicago**  
**Consent and Release Form**

**Name:** (First)\_\_\_\_\_ (Last)\_\_\_\_\_ **Date of Birth:**\_\_\_\_\_

**PROGRAM AND BACKGROUND**

You have requested to be treated with the Lipo-Light LED light therapy manufactured by Innovative Protonics LTD. This treatment is the application of a 635nm of LED light, which has been shown through extensive research to cause the fat within the adipose (fat cell) to leave the cell and accumulate in the interstitial space around the cells. The LED light used for this treatment has no effect on tissue. Instead, the non-invasive LED light helps the body break down 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. 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 advance so that you can decide whether to go forward with this procedure. Lipo-Light LED therapy has been approved by the FDA.

**PROCEDURE**

Initially you will consult with the therapist to determine if you are a candidate for the Lipo-Light LED therapy. During this time 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, there may be a few preliminary steps consisting of: initial paperwork, measurements, pre and post treatment photos and a suggested course of treatment.

The treatment will be administered by placing up to 16 Lipo-Light LED paddles with 30 diodes per paddle on the desired area(s) to be treated. The recommended course of treatment should be used in conjunction with a healthy diet and exercise. 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.

**RISKS/DISCOMFORT**

This treatment is non-invasive and 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

Lipo-Light is suitable for anyone over 18. This treatment would not be suitable for anyone pregnant or breastfeeding, or suffering from kidney or liver disease, cancer, heart disease, heart/pacemaker, autoimmune disease, metal pins/plates, thyroid problems or urine infection.

**BENEFITS**

Over the years the benefits of LED Light therapy have become more prominent. LED Light therapy 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 of excess pockets of fat can be targeted with the most commonly treated areas being the stomach, hips, flanks and thighs. In clinical trials patients have averaged 2-5cm lost from their stomach, hips and thighs. These results do vary and no guarantee is implied or suggested that desired results would be achieved with LED Light therapy alone.

## ALTERNATIVES

This is a strictly voluntary cosmetic procedure. No treatment is necessary or required and the client has chosen the Lipo-Light LED therapy voluntarily.

\_\_\_\_\_ **Initial**

## CONSENT

By signing below, you certify that this procedure has been explained to your satisfaction and have reviewed this Consent and Release Form. My consent and authorization for this procedure is strictly voluntary. By signing the informed consent, I grant authority to Achievement Chiropractic to perform the described treatment. The purpose of the procedure, risks/discomfort, benefits, and alternatives 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. You may experience increased redness to the area for up to 12 hours. You will be able to return to normal activities following the treatment. Any photos taken will be used to show the client's progress and may be used in marketing ads.

\_\_\_\_\_ **Initial**

## INITIALS AND SIGNATURE

I have been informed of the potential risks and side effects of Lipo-Light including, but not limited to, redness, swelling, heat sensitivity, pain, increase bowel movement 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 \_\_\_\_\_ treatments is required to achieve full results. 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 treatment depending on the client's 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. I know that if after the treatment course I gain weight, the results of the Lipo-Light may be reversed and there are no refunds.

\_\_\_\_\_ **Initial**

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 Release Form 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. If at anytime during the Lipo-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**

The undersigned assumes all responsibility for their behavior and the behavior of all persons on the premises by invitation of the client and all agree to abide by all Rules and Procedures of the property. The client and all persons on the premises by invitation of the client hereby hold Achievement Chiropractic, its employees, contractors, the legal entity or any individual connected in any way to Achievement Chiropractic harmless for any responsibility or liability for any accident, injury, illness or damages sustained by or to any client and their invited persons or their personal property during their treatment appointments or use of facilities. Achievement Chiropractic shall be indemnified and held harmless by the client and the client agrees to pay all costs incurred in connection with any accident, injury, illness or property damage or loss, including attorney's fees, regardless of how it may have occurred.

\_\_\_\_\_ **Initial**

The undersigned hereby releases and indemnifies Achievement Chiropractic and holds harmless any employees, contractors, the legal entity or any individual connected in any way to Achievement Chiropractic for any loss of personal property and/or accident causing personal injury of any nature, including reasonable attorney's fees and court costs in connection therewith.

\_\_\_\_\_ **Initial**

I further state that I am of lawful age and legally competent to sign this Consent and Release Form; I understand the terms herein is contractual and not a mere recital; I have signed this document of my own free act.

\_\_\_\_\_ **Initial**

### **VIBRATION FITNESS MACHINE**

Vibration fitness machines are scientifically calibrated exercise machines designed to force your muscles to stretch and contract very rapidly but in very small increments. What this does is replicate the same action that happens during traditional exercise very rapidly, therefore speeding up the needed exercise time. Vibration fitness uses your body weight as gravity to create the desired force and uses it to its fullest potential.

### **VIBRATION MACHINE RISKS**

Please do not use the vibration fitness machine without first getting approval from your doctor if you are pregnant, have 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, have cancer or a tumor, people with recent joint replacements or recently placed IUD's, metal pins or plates or if you have any concerns about your physical health. These contraindications do not mean that you are not able to use a vibration machine, but we do advise you to consult with your doctor first.

This is strictly a voluntary physical activity. No treatment is necessary or required and the vibration machine treatment has been chosen by the client. If at any time during the vibration machine session, I experience any pain or discomfort, I agree to inform the staff immediately and/or terminate the exercise at my discretion.

\_\_\_\_\_ **Initial**

**Due to demand for treatments, all cancellations require a MINIMUM of 24 hours' notice. Failure to provide a minimum of 24 hours' notice will result in that treatment being deducted from your course of treatment without a refund. Any changes to the initial treatment appointment dates will be subject to availability. If you are more than 5 minutes late we may not be able to accommodate your treatment appointment, as this may inconvenience other clients, as such Achievement Chiropractic reserves the right to deduct a treatment from your treatment course without a refund.**

\_\_\_\_\_ **Initial**

At Achievement Chiropractic, we place the highest priority on the client's right to privacy. Our office staff is trained to protect your private health information. 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 email addresses in our databases without your permission.

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

**Signature of Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Therapist:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Copies of this form and signatures will be valid as if original if this document is digitally scanned.



