Client Name: _____ Date: _____ Temperature: _____

PLEASE REACH EACH QUESTION CAREFULLY	Yes	No
Have you experienced any of the following symptoms in the past 48 hours:		
- **Fever or Chills**		
- **Cough**		
- **Shortness of breath or difficulty breathing**		
- **Fatigue**		
- **Muscle or Body Aches**		
- **Headache**		
- **New loss of task or smell**		
- **Sore throat**		
- **Congestion or runny nose**		
- **Nausea or vomiting**		
- **Diarrhea**		

PLEASE REACH EACH QUESTION CAREFULLY	Yes	No
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with:		
- Anyone who is known to have laboratory-confirmed COVID-19?		
- Anyone who has any symptoms consistent with COVID-19?		

PLEASE REACH EACH QUESTION CAREFULLY	Yes	No
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may e sick with COVID-19?		
Are you currently waiting on the results of a COVID-19 test?		

PLEASE REACH EACH QUESTION CAREFULLY	
Did you answer NO to ALL QUESTIONS?	Access to PS Contouring Facility APPROVED. Thank you for helping us protect you and others during this time.
Did you answer YES to ANY QUESTION?	**Access to PS Contouring facilities NOT APPROVED. Please see Page 2 for further instructions. Thank you for helping us protect you and others during this time.**

Client:
Print Name: _____
Signature: _____
Date: _____

PS Contouring Technician:
Print Name: _____
Signature: _____
Date: _____

Filename: newclienthistoryform_web.docx

THE SCREENING YOU COMPLETED INDICATES THAT YOU MAY BE AT INCREASED RISK FOR COVID-19

IF YOU ARE NOT FEELING WELL, WE HOPE THAT YOU FEEL BETTER SOON!

Here are instructions for what to do next

1

If you are not already at home, please avoid contact with others and go straight home immediately.

2

Call your primary care provider* for further instructions, including information about COVID-19 testing.

3

Contact your supervisor (if you are an employee) or your contracting company (if you are a contractor) to discuss options for telework and/or leave.

Before going to a healthcare facility, please call and let them know that you may have an increased risk for COVID-19.

In case of a life-threatening medical emergency, dial 911 immediately!

RETURNING TO THE WORKPLACE

If you have had symptoms consistent with COVID-19 or have tested positive for COVID-19, DO NOT physically return to work until you get a medical evaluation and are approved to return to a work setting by your primary care provider*. Please call your supervisor to discuss when to return to work. Read more about when it is safe to be around others at *https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/end-home-isolation.html.*

If you have a chronic medical condition that causes COVID-19-like symptoms and you need to access a CDC facility within the next few days, please call CDC's Occupational Health Clinic at 404-639-3385 to determine whether you can safely be granted access to a CDC facility.

If you have been in close contact with someone with COVID-19 you should stay home and self-quarantine for 14 days before returning to work. Read more about when you should be in isolation or quarantine at *https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html*.

If you are currently isolating or quarantining because of concerns about COVID-19 OR you have a COVID-19 test pending, please contact your primary care provider* for guidance on when you can return to work.

- If you have an urgent need to come to campus while waiting for a test result, call CDC's Occupational Health Clinic at 404-639-3385.
- If you have an urgent need to end your quarantine period early, please ask your CIO Management Officer to send an email request to eocevent106@cdc.gov and eocoht@cdc.gov.

If you have additional questions about when you can return to work, please email OSSAM@cdc.gov. For information about COVID-19 and basic instructions to prevent the spread of disease, visit CDC's COVID-19 website at *https://www.cdc.gov/covid19*.

*If you are assigned to the COVID-19, Ebola, or Polio responses, or work in a lab, call CDC's Occupational Health Clinic at 404-639-3385 instead of your primary care provider for next steps. DO NOT physically go to a CDC Occupational Health Clinic location.

CDC

2

NEW CLIENT HISTORY FORM

Full Name: _____ Date: ____/____/____

Address: _____ Birth Date: _____ Sex:☐ M ☐ F

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____Work Phone: _____

Email: _____ Occupation: _____

How di you hear about us:* (If someone referred you here, please name them so that we may thank that person) _____

Referral:

Friend (give name) _____ ☐ Facebook ☐ Twitter☐ Instagram ☐ Website

☐ Snapchat ☐Pinterest

Social Media (Please indicate which version you used to find out about our office)

☐Facebook ☐Twitter ☐ Instagram ☐Website ☐Snapchat ☐Pinterest ☐Website ☐Other: _____

MEDICAL HISTORY

Do you have any chronic medical conditions which we should know about? ☐Yes ☐No

If so, please list: _____

Do you have any allergies to latex, medications, herbal or natural supplements? ☐Yes ☐No

If so, please list: _____

Do you have Hearing aids, Pacemaker or Hormone Pellets (where) or metal/medical devices implanted?

☐ Yes ☐ No Explain: _____

Do you have Type 1 or 2 Diabetes? ☐ Yes ☐No

List all current Medications including Vitamins: _____

Do you have or have you had Cancer in the last 12 months? ☐Yes ☐No

If yes, are you currently on chemotherapy? ☐Yes ☐No

Do you have a Thyroid Problem? ☐Yes ☐No

NEW CLIENT HISTORY FORM

Do you have High Blood Pressure or Cardiovascular conditions? ☐Yes ☐No

Women Only, are you currently pregnant or nursing? ☐Yes ☐No

Please give us your cent Weight _____ Height _____

What is your Ethnic Background? _____

Circle which applies to you:

	Epilepsy		Gallbladder Removed
	Infections		History of Gallstones
	Tumors		History of Liver Problems
	Skin Diseases		Are you currently dieting? Explain:
	Normal Skin Sensation		History of Colon problems including protruding/distended belly? Explain:
	Thrombosis/Phlebitis		Have you had any surgeries? Explain:
	Autoimmune Disease		
	Neck/Back Problems		

Typical Daily foods and drink intake:

Water, how Many Glasses?		Coffee, how may cups?	
Alcohol, how much?			
Soda or Carbonation? Type? How often?		Fast Food, type? How often?	
Tobacco Use		Recreational Drugs (Narcotics)	

Stress Level: _____Moderate _____Average _____Demanding

I, (print name) _____, consent to allow the staff members to consult with and evaluate me in order to determine if I am a good candidate for the Non-Surgical Body Contouring Program. I understand that photographs and measurements will be taken and kept in my file.

I agree that these forms have been completed truthfully and to the best of my knowledge/abilities.

Signature: _____ Date: _____

(if minor, parent's signature)

CONSENT FORM

Body sculpting increases flow of both lymphatic and circulatory systems, and it also helps with cleaning of the tissues. The main uses of body sculpting treatment are inch loss, diminishing of cellulite, and tightening of the skin.

Benefits:

Lose 1-3 inches per treatment with state-of-the-art equipment. Benefits are often immediate, but may be delayed in some people.

For Best Results:

A series of 9-12 body sculpting treatments is recommended per each area, but some individuals may require more treatments to achieve maximum results. There should be at least 3-5 days between each treatment. This is not a weight loss treatment, but an inch loss. The inches will only return if the client goes back to their old habits. Eating the right types of food, proper exercise, and drinking 8-10 glasses of water per day are highly recommended and encouraged. For best results, it is recommended that you exercise within 4-6 hours of treatment and avoid sugar and alcohol for 24 hours after each treatment.

Precautions:

Body sculpting treatments are not recommended if you are pregnant, breast feeding, have lymphatic disorder, acute illness, metal implants, pacemakers, or currently being treated for active cancer.

Waiver:

I understand that I am using the Relaxed Fitness Vibration 360 or equivalent machine provided at my own risk. Should I sustain an injury while using the equipment, I agree to not hold Perfect Storm Body Contouring (PS Contouring), the service provider responsible.

Acknowledgement:

I understand and acknowledge that payments for the above services are **non-refundable**. By my signature below, I certify that I have read and understand the contents of this Consent Form for PS Contouring. I further agree to provide 24-hour notice of a cancellation or change in appointment time, or I will forfeit a treatment off my package since treatments are by appointment only. There are no refunds if I am responding to treatment and decide to stop treatments. Should I decide to add an Ultrasound treatment and/or Radio Frequency treatment, that treatment will be considered an additional and separate treatment. This extra treatment must be paid for separately or deducted from the number of treatments in my package and or explained during consultation. Should the service provide wish to use any photos of my progress other than for my personal file, I will sign a separate Photo Release form.

Client Signature: _____ Date: _____

CANCELLATION POLICY

If there is a need to cancel for any reason, we ask for a 24-hour notice. Please understand that when you do not cancel or show up for an appointment, it is a cost to us. If you cannot provide us with a 24-hour notice, we may impose the following fees:

“No Show” for session:

*Loss of that treatment in your treatment package

Same day cancellation:

*$50.00 charge before your next scheduled treatment

I, _____, have read and understand the cancellation policy of the service provider and agree to abide by the above conditions.

Signature: _____ Date: _____

TERMS OF ACCEPTANCE/INFORMED CONSENT

Please read carefully and understand the contents of this form. Ask us if you not understand.

When a client seeks Body Contouring services and when the service provider accepts a client, it is essential that both are seeking and working for the same goals. We expect our clients to take full responsibility for their decisions to participate in any of the services/programs offered by this office. We do not identify, diagnose, or treat ANY condition or disease. We have only one goal: TO OPTIMIZE YOUR BODY'S ABILITY TO FUNCTION NORMALLY AND OPTIMIZE YOUR FAT-BURNING POTENTIAL. By reducing bio-stress levels, we allow the body's inborn self-correcting mechanism to work at maximum efficiency to restore, maintain and promote wellness.

We do not identify or diagnose any condition(s) or disease(s). We offer no treatment for any condition(s) or disease(s). We promise no cure from any disease(s) or condition(s). Instead, we facilitate your body's own self-correcting mechanism.

It is essential that you speak to your doctor prior to making any decisions about altering any medical regimen you are currently following, changing your diet, taking supplements, or going on an exercise and/or weight loss program. Getting your doctor's approval prior to starting any service/program at our office is critical and solely your responsibility. Should any health condition arise while you are a client, we recommend that you immediately see the appropriate health care provider.

Any options that are rendered by the staff and/or head personnel should NEVER be construed as medical advice but merely as opinions. If you like medical advice, please see one of our medical doctors. We will not deal with any medical condition.

With your signature below, you understand and voluntarily accept these risks and agree that neither the service provider, its staff, or any of its partners will be liable for any injury to you, including, but not limited to, personal bodily injury, death, mental injury, economic loss or any damage to you, your spouse, or relatives resulting from any act of the service provider, and its staff or anyone else using the facilities and that you acknowledge the inherent risks of the positions, movement, dietary/nutritional programs offered to and done to you at the service provider, with respect to your current or past condition(s). If there is any dispute between you and the service provider, and/or any of its staff, both parties agree to submit it to binding arbitration. We both agree to have a neutral arbitrator preside over any such dispute, not a judge or jury.

I, the undersigned, understand and accept the conditions as laid out in the “Terms of Acceptance” above.

Client print name: _____

Client Signature: _____ Date: _____

Office acceptance by: _____ Date: _____

SERVICE AGREEMENT

The following provisions apply to the services to be performed for (Client Name) _____

1. **SERVICES TO BE PROVIDED**
    a. The Office provides ultrasound, laser, and radio frequency treatments. (Initials) _____
2. **PAYMENT**
    a. Payment in full is to be made prior to the start of each session. (Initials) _____
3. **CLIENT COOPERATION**
    a. This Agreement contemplates full Client cooperation in the course of services agreed upon. This cooperation includes Client's agreement to remain active in the recommended program for body contouring visits. The Client recognizes that compliance with recommended services and service schedule is important and the Client agrees to follow the service plan and the course of treatment agreed upon. The Client understand that lack of cooperation, failure to keep appointments and engaging activities identified by the office as potentially counterproductive to the body may necessitate additional treatments to those otherwise provided for this Agreement. Our office policy requires 24-hour advance notice for appointment cancellation. Failure to do so may result in deduction of pre-paid visits and or enforcement of the cancellation policy fee(s). (Initials) _____
4. **TERMINATION**
    a. Subject to the provisions of paragraphs 5 and 6 of this Agreement, the Client may discontinue care and terminate this Agreement at any time by written notice to that effect delivered in person, or by mail, to the office. Such “notice of termination” shall discharge the office from all further obligations and/or duty to render care to the client. The office reserves the right to terminate this Agreement in its sole discretion notwithstanding any other terms or provisions of this Agreement. (Initials) _____
5. **NO REFUNDS IN THE EVENT CLIENT TERMINATES AGREEMENT**
    a. To encourage commitment and follow-through, the service provider offers no refunds. No refunds will be made on body contour treatments. There will be no exceptions. The prepaid program cannot be altered, shared or transferred, nor can it be combined with any other program. (Initials)
6. **NO GUARANTEE OF RESULTS**
    a. Client recognizes that neither Office personnel nor this Agreement provides a guarantee of results. The Office makes no guarantee of the extent or longevity of improvement to be expected. This Agreement deals solely with the services to be rendered and the fees to be paid for the care as provided. The Client's payment obligation is not contingent upon the outcome of services. Client's results can be hindered and/or suppressed by the consumption of the following, but are not limited to, alcohol, processed foods including, but not limited to, sugar-based foods and drinks, etc. It is recommended to consult your physician for dietary modification clearance if you have any questions or concerns.

7. TIME LIMITATION FOR SERVICES
    a. Client understands that unused visits will expire if not used within 120 days from the date Client starts the treatment unless the Office has been provided with advance notice in writing of leave of absence or other cause of delay. After 24 weeks, all outstanding services/visits will be void. (Initials) _____
8. RELEASE OF LIABILITY
    a. Client agrees to indemnify, hold harmless and release the service provider, its agents, employees, officers, directors, representatives, assigns, members, affiliated organizations, and insurers, and others acting on the Company's behalf, of all claims, demands, causes of action, and legal liability, whether the same be known or unknown, anticipated or unanticipated, and further agrees that except in the events of the Company's gross negligence or willful and wanton misconduct, no claims, demands, legal actions and causes of action, shall be made against the Company for any economic and non-economic losses of any kind. (Initials) _____
9. YOUR RESPONSIBILITIES
    a. Keep your appointments. We require 24-hour advance notice to reschedule/cancel an appointment.
    b. Follow your program as closely as possible. Report any deviations to the Office staff so that we can help you get back on track.
    c. If you have any challenges whatsoever, please share them with us immediately. Remember, it is in both our interests for you to succeed in achieving your goals.
    d. If you have any medical conditions, please share this program with your physician immediately. The service provider is not a medical facility and does not make medical decisions. (Initials) _____
10. GOVERNING LAW
    a. This Agreement shall be governed, construed and interpreted by, through and under the Laws of the State of _____.
11. COMPLETE AGREEMENT
    a. This Agreement constitutes the complete agreement and understanding between Client and Office and will not be changed or modified in any way unless agreed to by both parties in writing. (Initials) _____

THE CLIENT HAS FULLY READ THIS AGREEMENT AND ANY SUPPLEMENT HERETO, AND UNDERSTANDS AND AGREES TO ABIDE BY ALL OF THE TERMS HEREOF.

Client Name: _____ Date: _____

Client Signature: _____

OFFICE ACCEPTANCE:

BY: _____ Date: _____ _____

PHOTO RELEASE FORM

I hereby consent and agree that Perfect Storm Body Contouring has the right to take or use photographs of me (and/or my property) and to use these in any and all media worldwide including online, now or hereafter known, and for any purpose whatsoever.

I hereby release to Perfect Storm Body Contouring all rights to exhibit this work in print and electronic form publicly or privately and to market and to market copies. I waive any rights, claims or interest I may have to control the use of my identity or likeness in the photographs and agree that any uses described herein may be made without compensation or additional consideration of me.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: _____ **Date:** _____

Address: _____ **Phone:** _____

_____

_____

Signature: _____

Parent/Guardian name & signature (if under 18): _____

Witnessed by Perfect Storm Body Contouring: _____

Date: _____

Current Medications List

Name: _____ Emergency Contact Name/Phone: _____

Date Last Updated: _____ _____ _____ _____

Prescription Medications:

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Notes

Allergies

Pharmacy/Prescription Drug Plan


Body Contouring