



You are scheduled for a series of non-invasive treatments with the Emsculpt. The device is indicated for improvement of abdominal tone and strengthening of the abdominal muscles same as for strengthening, toning and firming of buttocks. **Initials:** \_\_\_\_\_

Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is 4. The treatment is typically about 30 minutes per session, with sessions separated by at least 2 days, depending on your needs. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on your condition. **Initials:** \_\_\_\_\_

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

**Initials:** \_\_\_\_\_

I acknowledge that successful treatment outcome can be affected by smoking or excessive alcohol consumption, as well as: eating disorders or on-going medication. While no special diet is required, you are encouraged to eat healthy to help promote and maintain results.

**Initials:** \_\_\_\_\_

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. **Initials:** \_\_\_\_\_

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

- metal or electronic implants  YES  NO
- cardiac pacemakers, implanted defibrillators, implanted neurostimulators  YES  NO
- drug pumps  YES  NO
- pulmonary insufficiency  YES  NO
- malignant tumor  YES  NO
- fever  YES  NO
- sensitivity or allergy to latex  YES  NO
- haemorrhagic conditions  YES  NO
- anticoagulation therapy  YES  NO
- heart disorders  YES  NO
- epilepsy  YES  NO

- recent surgical procedures  
(muscle contraction may disrupt the healing)  YES  NO
- areas of the skin which lack normal sensation  YES  NO

**If you answer YES to any of these questions, please specify:**

**Please answer the following:**

- Have you been pregnant?
  - C-section?
  - Vaginal birth?
- Are you satisfied with the strength of your core muscles?
- Are you satisfied with the shape of your buttock?

**For the full range of contraindications, warnings and cautions, consult your treatment provider.**

I am aware that the treatment cannot be applied over the head and heart. **Initials:** \_\_\_\_\_

I am aware that pregnancy and nursing are contraindicated, and pregnant women cannot undergo the treatment. **Initials:** \_\_\_\_\_

I understand that there are certain risks associated with Emsculpt treatments and they include but are not limited to: muscular pain, temporary muscle spasm, temporary joint or tendon pain and local erythema or skin redness.\* **Initials:** \_\_\_\_\_

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

I agree to before and after treatment photographs, measurements and weighing, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. **Initials:** \_\_\_\_\_

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. **Initials:** \_\_\_\_\_

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 and these questions have been answered in full to

my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects. **Initials:** \_\_\_\_\_

I have read the above information, and I request and give my consent to be treated with the Emsculpt by the physician(s) in this practice and his/her designated staff. **Initials:** \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date