



UltraShape Consent Form

Patient name _____

Treatment site: _____

I duly authorize Ultimate Image MedSpa to perform the UltraShape treatment. I understand that UltraShape is a pulsed mechanical ultrasound that permanently destroys fat cells in the treated area without causing damage to tissue and adjacent structures. _____ (client's initials).

I understand that treatment with the UltraShape involves a series of 3 treatments 2-4 weeks apart. I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment _____ (client's initials).

I understand that there are no serious Adverse Events related to the UltraShape treatment. I can expect some mild transient redness, and blisters may occur (in rare cases 0.05% reported) _____ (client's initials).

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken. I will notify a clinic staff member if my health status changes or medication is prescribed by another Physician at any time during my treatments _____ (client's 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 _____ (client's initials).

I have been explained the fee structure for UltraShape. I also understand there is a non-refundable \$50 fee for the SpaKinect medical approval required for this service. _____ (client's initials).

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion _____ (client's initials).

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form _____ (client's initials).

Client Signature _____ **Date** _____

Technician Signature _____ **Date** _____



Cancellation and No-Show Policy

Your treatment schedule is very important to us. We make every effort to keep all clients within the proper time frame for optimum results, however, we understand that life happens, and you may need to reschedule. In consideration of others, we **require** at least 24 hours of notice for cancellations.

Late arrivals: We will do our best to accommodate. Rescheduling will be necessary if our schedule cannot permit the time.

We are available via phone at 972-800-2127 during our business hours OR you may submit your request to info@UltimateImageSkincare.com

Late Cancellation Fee: Clients who cancel their appointment on the same day will be charged \$35.

No Show Fee: Clients who completely miss their appointments without giving us any prior notification or cancellation at the time of the appointment will be charged \$50 or lose the scheduled service.

~~~ ALL SALES ARE FINAL ~~~

I have read and understood all the information presented above.

Client Signature: _____ **Date:** _____