Name_____ **Date**_____

Age_____ **Sex: M / F** **Current Weight**_____ **Desired Weight**_____

To be filled out by Skinny Beam specialist.

	Before	After	Loss
Chest	CM	CM	CM
Waist	CM	CM	CM
Belly	CM	CM	CM
Hip	CM	CM	CM
R Thigh	CM	CM	CM
L Thigh	CM	CM	CM

TOTAL:_____CM /2.54CM = _____IN.

Your success is our #1 priority.

Name:		Age:		D.O.B	
Address:		City:		Zip:	
Email:		Cell :			
Marital Status:		Occupation:			

Do you exercise?		How often?	
What type of exercise?			
What worries you most about weight loss?			
What do you expect from your **Skinny Beam** Treatment?			
If you were referred by one of our clients, please tell us who we can send a thank you note to.			

By signing below, the undersigned agrees to follow these directions to assist in achieving the best results possible for these treatments. The undersigned also agrees to allow the release of all photos taken of the undersigned individual to **Skinny Beam** and allow these photos to be utilized in advertisements or **Skinny Beam** treatment in both print and electronic form (email, websites, etc). The undersigned individual's identity will be hidden to the best of **Skinny Beam's** ability. By signing below, the undersigned releases all right to sigh photos of themselves.

By signing below, Buyer agrees to the terms and requirements of this Agreement.

Signature _____ Printed Name _____ Date_____

SYMPTOM	NONE	MILD	MODERATE	SEVERE	
Hot Flashes					Low Estrogen
Night Sweats					
Vaginal Dryness					
Incontinence					
Irregular Periods					Estrogen Dominant
Uterine Fibroids					
Water Retention					
Tender Breasts					
Fibrocystic Breasts					
Increased Forgetfulness					
Foggy Thinking					
Tearful					
Depressed					
Mood Swings					
Stress					Adrenals
Morning Fatigue					
Evening Fatigue					
Difficulty Sleeping					
Decreased Stamina					
Anxious					
Irritable					
Nervous					
Ringing In Ears					
Fibromyalgia					
Allergies					
Headaches					
Sugar Cravings					
Dizzy Spells					
Cold Body Temperature					Thyroid
Goiter					
Hoarseness					
Nails Breaking or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					
Infertility Problems					Metabolic Syndrome/High Androgen
Acne					
Increased Facial/Body Hair					
Scalp Hair Loss					
Weight Gain-Hips					
Weight Gain-Waist					
High Cholesterol					
Elevated Triglycerides					
Decreased Libido					Low Androgen/Other
Decreased Muscle Size					
Thinning Skin					
Rapid Aging					
Aches & Pains					
Bone Loss					

Goals

Current Weight_____ Desired Weight_____

Desired Completion Date:_____

Weight loss can be complex. If you have experienced failure in the past, it could be because you have some of the following symptoms.
Please check all that apply.

	Abdominal Pain		Fatigue		Fibromyalgia
	Diarrhea		Difficulty getting to sleep		Depression
	Constipation		Difficulty staying asleep		Menopause
	Gas after meals		High amounts of stress		Back pain
	Frequent urination		Over Heating		Muscle pain
	Sugar cravings		Cold hands and feet		Joint pain
	Irritable if meals missed		Take pain medication		Knee pain
	Fatigue after meals		Low sex drive		Hip pain

Medications, vitamins, supplements	List ALL surgeries

Consent and Release of Liability Form, Informed Consent Release, and Indemnity Agreement

First name	Last Name	Date

Program and Background

You have requested treatment utilizing **Skinny Beam** LED light therapy manufactured by **Skinny Beam**. This treatment is the application of a 635nm light, which causes fat within the adipose (fat) cell to leave the cell and accumulate in the cell's interstitial space, utilizing stimulating of its biological function to help the body break down fat. This excess fat is moved by the body's lymphatic system and excreted without negative side effects or downtime. Any medical or cosmetic procedure carries risks, complications, and varied results. The purpose of this document is to inform the client of the nature of this product and its risk. **LED therapies have been approved by the FDA.**

Procedure

Initially you will consult with a Skinny Beam specialist to determine if you are a candidate for the LED therapy. 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 the procedure then paperwork, measurements, pre and post treatment photos (upon your approval), and a suggested course of treatment will be given. The treatment is administered by placing up for 4 LED pads on the desired area(s) to be treated. It is recommended that a patient may need between 9-12 treatments for the LED therapy to achieve the desired effect. This treatment should be used in conjunction with a healthy diet and exercise. You should consult a health care professional before beginning any new exercise program to determine if your body is physically able.

Risks/Discomfort

This treatment is non-invasive. During treatment there should be no discomfort. The client will feel only the warmth of the light. **Skinny Beam** is suitable for anyone over 18. Anyone with any of the following would not be suitable for this treatment: pregnant, breast feeding, kidney or liver disease, cancer, or auto-immune diseases.

Benefits

LED light therapy has become more prominent and has been used in many studies for pain management and recently by cosmetic surgeons to emulsify adipose tissue before liposuction with FDA approval. The potential benefit of this treatment is body contouring without surgery. Problem areas or excess pockets of fat can be targeted, however the most commonly treated areas are the stomach, hips, flanks, and thighs. In clinical trials patients have averaged 2-5cm lost from their stomach, hips, and thighs individually. These results do vary and no guarantee is implied or suggested that the desired results will be achieved.

Questions and Explanations

By signing below, you certify that this procedure has been explained to you and your satisfaction, and that you have been fully informed of the nature and purpose of the **Skinny Beam** procedure, expected outcomes, and possible complications, and understand that no guarantee can be given as to the final result obtained. You are fully aware that your condition is of a cosmetic concern and that the decision to proceed is solely based upon your expressed desire to do so. You are aware that **Skinny Beam** may/can cause slight hypo/hyper-pigmentation of the skin and treatment is taken at your own risk (tattoo areas should be avoided). Any further questions can be directed to a **Skinny Beam** specialist. You further state that you are of a lawful age and legally competent to sign this aforementioned release, and that you understand the terms herein is contractual and not a mere recital; you have signed this document of our own free act.

Whole Body Vibration Plate Exercise Risks

Whole Body Vibration Plate Machines are scientifically calibrated exercise machines designed to force your muscles to stretch and contract rapidly in small increments, replicating the same action which occurs during traditional exercising, therefore speeding up the needed exercise time. Vibration exercises use your body weight and gravity to its fullest potential. Please do not use a whole body vibration plate or any other exercise device without getting approval from your doctor if you are in the following group: pregnant women, 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, spondylolisthesis, spondylosis, have cancer or tumors, people with recent join replacements, or recently placed IUD's, mental pins or plates, or any other concerns about your physical health. Frail individuals and children should be accompanied by a responsible adult. These contra indications do not mean that you are not able to use a vibration or other exercise device, but we advise you to consult a doctor first.

_____INITIAL I understand that using a whole body vibration machine workout is a strictly voluntary physical activity chosen by myself (the client). If at any time I experience pain or discomfort of any kind, I agree to inform the staff immediately and/or terminate the exercise.

Voluntary Cosmetic Procedure

_____INITIAL I understand that this is a strictly voluntary cosmetic procedure. No treatment is necessary or required and the **Skinny Beam** LED therapy has been chosen by me (the client).

_____INITIAL I have been informed of the potential risks and side effects of **Skinny Beam** including but not limited to redness, swelling, heat sensitivity, pain, increased bowel movements, and increased urination. The risks, potential damages, and adverse side effects have been explained to me and I fully understand.

_____INITIAL I understand that if I gain weight after the treatment course, the results of **Skinny Beam** will be reversed.

_____INITIAL I understand that no guarantee has been given as to the results that may be obtained by this treatment. I have read this informed consent 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. I hereby give my consent to have this procedure. If at any time during the **Skinny Beam** 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 I duly authorize technicians to perform the procedure for the purpose of body contouring, lymphatic drainage, improvement of cellulite, and skin tightening. I am aware that clinical results may vary depending on individual factors, medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. **If I do not make an effort to address my diet and exercise, the results achieved may not be retained.**

_____INITIAL I have reviewed this consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form I grant authority to perform the described treatment. The purpose of this procedure, risks, complications, and alternative methods of treatment 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. Increased redness to the area for up to 12 hours may be experienced (although this is unlikely). Normal activities may be resumed following the treatment. Any photos taken will be used to show the clients progress and may be used in marketing ads.

I further state that I am of lawful age and legally competent to sign this aforementioned release. The procedures, alternative and risks have been explained to me and I have been given the opportunity to ask questions. I understand it is my responsibility to inform the staff if there are any changes to my medical history. I understand the terms herein is contractual and not a mere recital. I have signed this document of my own free act.
I HAVE CAREFULLY READ, UNDERSTAND, AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS.

_____ _____
Client Date

_____ _____
Management Date

Agreement

_____ (patient) agree to undergo a series of treatments offered by **Skinny Beam**. In order to provide the highest level of service and to deliver the best results possible, there are specific directions an individual must follow while receiving these treatments. Skinny Beam treatments involve exposure of low level light energy in the wavelength of 635nm that does not generate heat and is painless. Studies prove that 635nm will excite the mitochondria within the fat cell; this reaction is called photo-biostimulation and causes the cell to release its contents without injury to your cells or your body. The contents of a fat cell are triglycerides, consisting of water and stimulating the lymphatic system. By drinking a sufficient amount of water and stimulating the lymphatic system with some very light exercise, these fatty acids will be transported to the liver. By taking supplements to assist the liver in processing excess fatty acids, less of these aids will return to the fat cells, and the majority of the fatty acids will be directed to the kidneys and eliminated. Additionally, if a healthy diet is followed and a supplement is take that assists the body in reducing the conversion of carbohydrates into fatty acids, less volume will return to the fat cells. Please review these directions and place your initials where required:

1. Treatments cannot be scheduled closer than 48 hours together.

   _____ (initial)
2. Do not eat 2 hours before or 2 hours after each treatment.

   _____ (initial)
3. Exercise immediately after each treatment (whole body vibration, 10 minutes on an elliptical machine, brisk 10-minute walk, etc)

   _____ (initial)
4. Maintain a healthy diet of low carbohydrates / low fat that is designed, at a minimum, to maintain your weight and not cause you to gain weight.

   _____ (initial)
5. Drink at least _____ ounces of water per day (0.5 ounces of water for each pound of body weight).

   _____ (initial)
6. Take the E2 Ultra Slim Cleanse supplement product twice a day as directed on the bottle.

   _____ (initial)
7. Take the E2 Slender Sea Pak supplement product twice a day as directed on the bottle.

   _____ (initial)
8. **Reduce or eliminate alcohol consumption while receiving these treatments (alcohol interferes with liver function, reducing its ability to process fatty acids).**

   _____ (initial)

Policies and Terms Agreements

Cancellation Policy

We require a 24-hour cancellation notice. Due to demand for treatments, we schedule all appointments following the initial consultation.

- If I cancel within 24 hours of a reserved session, I will lose or forfeit my session
- If I cancel within 24 hours of a reserved session, I might incur a $50 no-show fee

If I fail to show up or am more than 5 minutes late I will lose or forfeit my session due to staff wages and fees paid for my session, and to avoid inconveniencing other clients scheduled after me.

Our cancellation policy has been created to ensure our loyal clients are not disturbed by the tardiness of clients who do not show up on time, or who cancel without a valid reason within 24 hours of an appointment. When reserved sessions are unattended, this means that loyal clients missed the opportunity of having that particular time period. Thank you for your understanding.

Purchase and Reservation Policy

Sessions will only be confirmed and allowed up to the amount of pre-paid sessions. All sales are final and non-refundable. We reserve the right to terminate any client's session, package, or contract without refunding any monies, if the client has broken any terms or policies. All purchases are final, non-refundable and non-transferable.

Groupon Policy

At the time you book your first appointment Skinny Beam is required to ask for your Groupon voucher number and we reserve the right to redeem the full package amount to hold your spot. Once a client is seen for a consultation and completes the first session, the Groupon package is non-refundable. There is no partial refund for appointments the client chooses not to complete.
You can reschedule your first appointment within 24 hours.
No-show, No-call appointments: We reserve the right to redeem the full package of the Groupon and to cancel all future appointments.
For established clients: Please call 24 hours in advance to cancel or reschedule

The terms herein are contractual and not a mere recital. I have signed this document of my own free act.

_____ _____

Client Signature Date