



## GENERAL PATIENT RECORD

<b>Patient's name:</b>	<b>Date of birth:</b>
<b>Phone:</b>	<b>Email:</b>

You are scheduled for a series of non-invasive treatments with the EMSCULPT NEO. The device is indicated for non-invasive lipolysis (breakdown of fat) of the abdomen and for reduction in circumference of the abdomen in Skin Types I to III. The device is also cleared for improvement of abdominal tone, strengthening of the abdominal muscles, development of firmer abdomen. Strengthening, toning and firming of buttocks, thighs and calves. Improvement of muscle tone and firmness, for strengthening muscles in arms. **Initials:** \_\_\_\_\_

Your treatment provider will discuss your specific treatment needs. The recommended number of treatments is 4. The treatment is typically about 20-30 minutes per session, with sessions separated by 5 to 10 days. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments, depending on your goals. **Initials:** \_\_\_\_\_

Before the treatment, you are not required to do anything special, however, keeping your body well hydrated is strongly recommended. On the day of the treatment, you are advised to wear comfortable clothing, allowing flexibility for correct positioning during the treatment. You will be asked to remove all metallic accessories and electronic devices. **Initials:** \_\_\_\_\_

I acknowledge that a successful treatment outcome can be affected by smoking or excessive alcohol consumption and 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:** \_\_\_\_\_

The treatment does not require anesthesia. During the application, you will feel intense muscle contractions and heating sensation 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:** \_\_\_\_\_

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I am aware **NOT TO** wear any metallic accessories (such as jewelry, watch or clothes containing metallic threads or metallic accessories) during the treatment. I also acknowledge that I do not have any metallic or electronic implants (such as pacemakers, defibrillators, metallic IUDs, etc.) **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
- Cardiovascular diseases  YES  NO
- Disturbance of temperature or pain perception  YES  NO
- Septic conditions and empyema  YES  NO
- Acute inflammations  YES  NO
- Systemic or local infection such as osteomyelitis and tuberculosis  YES  NO
- Contagious skin disease  YES  NO
- Elevated body temperature  YES  NO
- Pregnancy, post-partum period, nursing and menstruation  YES  NO
- Basedow's disease  YES  NO
- Metallic IUD  YES  NO
- Hemorrhagic conditions  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:**

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**Please answer the following:**

- Have you been pregnant?
  - C-section
  - Vaginal birth
  
- Are you satisfied with the strength of your core muscles?  YES  NO
- Are you satisfied with the shape of your buttock?  YES  NO
- Are you satisfied with the tone of your arms?  YES  NO
- Are you satisfied with the tone of your calves?  YES  NO

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

**Treatment considerations**

- I am aware that the treatment cannot be applied over the head, heart and neck. **Initials:** \_\_\_\_\_
- I am aware that pregnancy is contraindicated, and pregnant women cannot undergo the treatment. **Initials:** \_\_\_\_\_
- I am aware that the applicators must be in full contact with the bare skin. I am aware that the therapy can't be performed through clothing. **Initials:** \_\_\_\_\_
- I understand that there are certain risks associated with EMSCULPT NEO treatments and they include but are not limited to muscular pain, intramuscular fat decrease, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness, localized overheating, increased menstrual flow in female patients and panniculitis\*. **Initials:** \_\_\_\_\_
- I understand that the treatment over injured or otherwise impaired muscles is contraindicated\* **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:** \_\_\_\_\_

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- 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 NEO 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.

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness (in print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Practice Name:** \_\_\_\_\_

\*For the full range of possible adverse effects and expected device-related treatment sequelae, consult your treatment provider.

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Patient's name or ID: \_\_\_\_\_

Treatment area(s): \_\_\_\_\_

Height: \_\_\_\_\_ || Age: \_\_\_\_\_

SESSION #	DATE	PROTOCOL	TREATMENT TIME	HIFEM INTENSITY	RF INTENSITY	CIRCUMFERENCE MEASUREMENT	WEIGHT (each visit)	PHOTO (each visit)
1								YES/
2								YES/
3								YES/
4								YES/
5								YES/

**COMMENTS:**