MedUltima Aesthetics, LLC

Where Beauty Meets Health

BTL CELLUTONE

GENERAL PATIENT RECORD

Patient's name:_____ **Date of birth:** _____
Age: _____ **Phone:** _____ **Email:** _____

You are scheduled for a series of non-invasive treatments with the BTL Cellutone device. Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is 4-6, with the frequency of 1-2 treatments per week. You may need additional treatments depending on the severity of your condition. For optimal results, it is important to follow the treatment plan that has been established for you. The results will typically continue to improve over the next few weeks. Initials: _____

Please arrive at your appointment well hydrated. Ideally, you should hydrate 2 days before, on the day of the treatment, and 4 days after the treatment. This will result in a more comfortable and efficacious treatment. Initials: _____

On the day of the treatment, it is recommended to wear comfortable clothes which allow easy access to the treated area. You will be asked to remove any jewelry from the area of interest. Initials: _____

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

There is typically no downtime associated with your treatment and there is no anesthetic required. Most patients describe the sensation of the therapy such as comfortable but intense mechanical vibrations. Initials: _____

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

- Coagulation disorders, thrombosis ☐ YES ☐ NO
- Cardiovascular disorders ☐ YES ☐ NO
- Metal or electronic implants in the treated area, implanted cardiac pacemakers ☐ YES ☐ NO
- Malignant or benign tumors ☐ YES ☐ NO
- Diabetes mellitus ☐ YES ☐ NO
- Arterial hypertension ☐ YES ☐ NO
- Serious renal or hepatic insufficiency ☐ YES ☐ NO
- Venous surgery on legs/sclerotherapy ☐ YES ☐ NO

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

_____

_____

_____

_____

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

▪I am aware that pregnancy and nursing are contraindicated and pregnant women can't undergo the treatment. Initials:_____

▪ I understand there are certain risks associated with BTL Cellutone treatments and they include but are not limited to: local erythema, swellings, temporary loss of bodily sensation or itching, hematoma and petechiae. 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 weighting, 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 BTL Cellutone procedure by the physician(s) in the below stated practice and his/her designated staff. Initials:_____

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

Patient's signature: _____ Date: _____
Witness: _____ Signature: _____ Date: _____
Practice Name: _____

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