MD WELLNESS CENTER AND MED SPA

Dr. Srinivasu Kesa, MD
American Board of Obesity Medicine
www.MyTrimMD.com
contact@mytrimmd.com

6822 E 82ND ST. SUITE #300 INDIANAPOLIS IN 46250 317.548.4666 317.650.2501 317.350.0059

Name:		**Date:**
Address:		
City:		Zip Code:
Home Phone:		
Mobile Phone:		
E-mail:		
Date of Birth:		Age:
Marital Status:		Gender:
Occupation:		
Primary Care Physician: Name:	Contact Information Phone Number: Fax Number:	
Emergency Contact:	Name: Relationship:	Mobile Phone:
Do you exercise?		
How often?		
What kind of exercise?		
How did you hear about us?		
Did anyone refer you to us?		
What are you expecting from this procedure?		

Medical History :	
Are you pregnant?	Are you Nursing?
Do you have a Bleeding Disorder?	Are you on blood thinners?
Do you have any metal implants on body including but not limited to – defibrillators, pacemakers, insulin pumps, previous bypass surgery wires, joint replacements, neurostimulator, IUDs, screws, plates, and/or any other? (Circle the ones that apply)	
Do you have Current or History of Cancer?	
Do you have Skin Cancer?	
Do you have any pre-malignant moles?	
Do you have Diabetes mellitus?	
Do you have AIDS or any other immunosuppressive disorders?	
Do you use Retin A or Retinol in the treatment area?	
Do you have Rosacea?	

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Do you have a History of Herpes Simplex in the treatment area?
Do you have a rash in treatment area? (Sores, Psoriasis, etc.)
Do you have any allergies to skin or cosmetic products?
Do you have varicose veins in the treatment area?
Do you have any surgical scars in the treatment area?
Do you have any Keloid scarring in the past?
Do you have any medical condition(s) that might impair skin healing?
Do you have a Hernia in the treatment area?
Do you have any active cancer?
Do you have Hepatitis C and/or D?
Do you have any auto immune disease(s)?
Do you have any neuropathies?
Do you have very fragile, dry skin or any skin disorder that makes it harder for skin to heal?
Have you had any filler treatments done recently?

Consent Section:

Any medical or cosmetic procedure carries risk, complications and varied results as to the effectiveness of a particular treatment. The purpose of this document is to make you aware of the nature of MD Medical Weight loss and Wellness Center's products and its risks in advanced so that you can decide whether to go forward with any procedures/treatments.

_____ **Initials**

Procedures:

Initially, you will meet with our consultant to determine if you are a candidate for Body contouring or Skin Tightening procedures or any other inch-loss procedures. During this time, 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 any procedure, there will be a few preliminary steps consisting of: initial paperwork, measurements, pre- and post- treatment photos and suggested course of treatment. It is recommended that a client will need a minimum NUMBER OF (varies from area of treatment and treatment chosen) treatments for the therapy to achieve its desired effect. These treatment should be used in conjunction with a healthy diet and exercise. If you are not currently exercising, you should consult a health care professional before beginning an exercise program to determine if your body is physically able.

Benefits:

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 there stomach, hips, and thighs. These results vary and no guarantee is implied or suggested that desired results will be achieved.

Risks/Discomfort:
Our treatments are non-invasive. During treatment there may be discomfort and/or a sensation of heat. If for any reason during treatment the client feels that discomfort is more than expected, please notify the therapist immediately. If client chooses to continue through any discomfort, it is at the client's own risk and provider assumes no responsibility. Procedures are recommended for anyone over 18.

Anyone with the following would NOT be suitable for treatments:

- Pregnant
- HIV – AIDS
- Hepatitis C and/or D
- Active Cancer
- Heart disease (not under the control of a physician)
- Heart/pacemaker
- Autoimmune disease (not under the control of/or monitored by a physician)
- Thyroid problems (not controlled by medication)

Alternatives:
This is a strictly voluntary cosmetic procedure. No treatment is necessary or required and the procedure has been chosen by the client.

Consent:
I have reviewed this consent form. My consent and authorization for procedures are strictly voluntary. By signing the informed consent form I grant authority for MD Medical Weight Loss and Wellness Centers to perform the requested treatment. The purpose of this procedure, risks, complications, 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. You may experience increased redness to the area or light abdominal discomfort for up to 12 hours. Any photos taken will be used to show the clients progress and may be used in marketing ads.

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

By signing below, you certify that this procedure has been explained to you and your satisfaction. Any further questions can be directed to a MD Medical Weight Loss and Wellness Center's Specialist.
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I understand that in order to see the best results, I need to follow instructions given by MD Medical Weight Loss and Wellness Centers and get full number of treatments as recommended by them. At that point, I will be re-evaluated to see if more sessions are needed in order to achieve realistic goals. Each body is different and may require more or less treatments depending on the client's diet, exercise, metabolism and body type. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program. I know that if after the treatment course I gain weight or do not maintain lifestyle, the results of the treatment may be reversed.
_____Initials

No guarantee has been given by anyone 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.
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If at any time during the procedures I experience pain or discomfort of any kind, I agree to inform the staff immediately and/or terminate the session at my discretion. The undersigned assumes all responsibility for behavior of self and their clients and agrees to abide by all Rules and Procedures of the property. The clients and all persons on the premises by invitation of the clients hereby hold MD Medical Weight Loss and Wellness Centers and its employees, independent contractors, the LLC or any individual connected in any way to MD Medical Weight Loss and Wellness Centers, harmless for any responsibility or liability for any accident, injury, illness or damages sustained by or to any person or their personal property during their treatment appointments or use of facilities. MD Medical Weight Loss and Wellness Centers shall be indemnified and held harmless by the clients, and clients agree to pay all costs incurred in connection with any accident, injury, illness or property damage loss, including attorney's fees, regardless of how it may have occurred.
The undersigned hereby releases and indemnifies MD Medical Weight Loss and Wellness Centers and holds harmless any employee, the LLC or any individual connected in any way to MD Medical Weight Loss and Wellness Centers for any loss of personal property and/or accident causing personal injury of any nature, including reasonable attorney's fees and court costs in connection therewith.
I further state that I am of lawful age and legally competent to sign this aforementioned release; I understand the terms herein is contractual and not a mere recital; I have signed this document of my own free act.
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At MD Medical Weight Loss and Wellness Centers, we place the highest priority on the client's right to privacy. Our office staff is trained to protect your private health information. We value your privacy, and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. We do not disclose identifiable information to any third party without your consent. Furthermore, we

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do not sell, rent, or otherwise allow the unauthorized outside use of personal information such as names, addresses, phone numbers, or e-mail addresses in our database without your permission. Copies of this form and signature will be valid as if original if this document is digitally scanned.
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CLIENT AGREEMENT

HEALTH: I am over the age of eighteen and in apparently healthy condition. I understand the above potential risks and benefits of these services. I understand that injury can be unrelated to the technician, instruction or equipment.
ACCIDENT / INJURY: I agree that all exercise and the use of this facility are undertaken by me at my own risk and MD Medical Weight Loss and Wellness Centers, LLC shall not be liable for any claim of injuries or damages whatsoever. I agree to hold the MD Medical Weight Loss and Wellness Centers, LLC, their employees, contractors, and associates not responsible for any claims or negligence.

Cancellation/Reschedule Policy:

We are requesting that you please call if you are unable to make a Class, Body Contouring session or Consultation appointment. All appointments missed without notifying us ahead of time will not be able to be made up due to the effect that "no shows" have on our scheduling process.
If prior notification is given, your appointment and/or consult will be able to be made up.
We are always glad to reschedule an appointment as we understand that unexpected conflicts do come up. Please call and we will do our best to get you in at the most convenient time for you.
If I am more than 10 minutes late for an appointment, without calling, MD Medical Weight Loss and Wellness Centers may not guarantee I will be seen. If my therapist cannot fit me into the appointment schedule, I will be **charged a $49 missed appointment fee.**
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Refund Policy:
I understand that as a recipient of services, I, the undersigned, am responsible for all charges, regardless of my circumstances. I agree that the determination of the professional services to be rendered by the facility and the fees to compensate for these services are matters which concern me and MD Medical Weight loss and Wellness centers. I understand that I have the primary duty and obligation to pay for services provided, notwithstanding any contract I may have with any third party payer (i.e. insurance company, employer, etc.) All sales are final. By purchasing a product or service, a person is acknowledging that they know and understand what they are buying and agree all sales are final. If at any time, I choose to put my services on hold I may do so as long as it is utilized within 180 days from date of written notice is provided to MD Medical Weight loss and Wellness centers. A written letter, detailing why you wish to place services on hold or discontinued, is mandatory for any services held.

Once sessions are started there are no refunds provided. You may use the remaining sessions for up to 6 months after written notice is provided.
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All returned checks or insufficient electronic funds returned by the bank will incur $25 fee and charged to the client along with outstanding balance. No further checks will be accepted from client.
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I UNDERSTAND THAT THIS IS MY RESPONSIBILITY TO KNOW THE TERMS OF MY AGREEMENT AND I AGREE TO COMPLY WITH THE TERMS.

I HAVE READ AND AGREE TO ALL TERMS OUTLINED ABOVE

Signature _____ **Date**_____