J+MED on Madison

Japanese Medical Care, PLLC

Instasculpting Consultation Form

Full name:_____D.O.B:_____Age: _____Gender: _____

Address: _____City: _____State: _____Zip:_____

Phone: _____Email:_____

Emergency contact: _____ and phone:_____

To perform Instasculpting procedure in a safe manner, please answer the following health questions truthfully. We will keep all information disclosed in a confidential manner and will use it only for the purpose of determining whether you are an ideal candidate for this procedure.

Medical history

Please check all that apply:

☐ Check this box if you have any of the following conditions, doctor's permission may be required.
Consult your doctor about the InstaSculpting treatment is recommended.

Epilepsy, Diabetes, High Level of Cholesterol, Hypertension, Liver Disease/Condition, Kidney Disease/Condition, Deep Vein Thrombosis/Pulmonary Embolism, and/or other Cardiovascular Disease/Condition.

☐ **Y** ☐ **N** Heart Pacemaker or Other Electronic Devices

☐ **Y** ☐ **N** Pregnancy *(eligible for facial skin tightening)* or Current Breastfeeding

☐ **Y** ☐ **N** Previously or Recently Diagnosed Cancer, including Melanoma

☐ **Y** ☐ **N** Any Communicable Diseases, Infections, or Tuberculosis

☐ **Y** ☐ **N** Recent *(within 6 months)* Surgical, Invasive, Ablative Procedure, including Plastic Surgery

☐ **Y** ☐ **N** History of Internal Bleeding

☐ **Y** ☐ **N** Transplants

☐ **Y** ☐ **N** Any Acute or Chronic Inflammation

☐ **Y** ☐ **N** Any Medical Condition that Might Impair Skin Healing

☐ **Y** ☐ **N** Migraine headache and/or Vertigo

☐ **Y** ☐ **N** Areas of Sensory Impairment such as in cases of Nerve Lesions and Neuropathies

☐ **Y** ☐ **N** Any Acute Skin Conditions such as Unhealed Wound, Burn, Eczema and Rash

☐ **Y** ☐ **N** Any Type of Implant. If you have, Where _____

☐ **Y** ☐ **N** Keloids

Continued questions at the back

424 Madison Ave, Fl 7
New York, NY 10017
Phone: 212-204-8567 Fax: 212-808-5510

Japanese Medical Care, PLLC

For Face Skin Tightening Specific: check all that apply.

☐ **Y** ☐ **N** Lose Breath Easily

☐ **Y** ☐ **N** Thyroid Disease

☐ **Y** ☐ **N** Botox, When and Where _____

☐ **Y** ☐ **N** Filler, Where _____

If you answer **YES** to any of the above condition(s), please explain

_____

Any known allergies? If yes, please specify_____

List any medications you are currently taking_____

Have you ever had any weight loss treatment previously? If yes, please specify_____

What is your primary area(s) of concern? _____

What is your goal? _____

Do you currently follow a diet plan? If yes, please specify _____

Are you having regular exercise? If yes, how often and what type? _____

Do you drink alcohol? ☐ Not at all ☐ once a month or less ☐2~4 times a month ☐2~3 times a week ☐4+ times a week

Do you drink water daily? ☐ Not at all ☐ 1~2 bottles ☐ 3~4 bottles ☐ 5~6 bottles ☐ 7+ bottles

When is your next menstrual cycle due to begin? _____ ☐ Not applicable

***DO NOT schedule Treatments during your cycles.**

Your cycle will become heavy, and the Treatment result may be affected due to bloating.

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. Due to the potential risk of negative reactions during the Treatment or subsequent side effects that may impact my recovery, I understand that I must disclose all prescription and non-prescription (i.e., over-the-counter) medications that I am currently taking, as well as inform Japanese Medical Care, PLLC of any changes in the above information prior to start of the Treatment.

Printed Name_____ Date_____

Signature_____

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Japanese Medical Care, PLLC

Instasculpting Consent Form

I hereby request and authorize Japanese Medical Care, PLLC and its staff and physicians (collectively, "the Practice") to perform Instasculpting treatments upon my person (the patient) ("Instasculpting" or the "Treatment").

Treatment Disclosure

I understand that the Treatment combines the use of ultrasonic cavitation and radio frequency. Ultrasonic cavitation emits sound waves which causes the destruction of fat cells, collagen stimulation and tightening of the skin. The strong sound waves cause fat cells to rupture and metabolize through the lymphatic system. Radio frequency is used to stimulate collagen, lift and tighten loose skin and minimize fine lines. The high frequency waves penetrate deeply into the skin causing rapid expansion and heating of the cell wall, causing the cells to break down.

While the Treatments may cause a reduction in body fat which leads to a reduction in body size, I understand and acknowledge that Instasculpting is for cosmetic purposes only and **not a weight loss treatment**. I further acknowledge that the Treatment, while a medical procedure, is not intended to diagnose or treat any illness or other medical condition.

I also understand that the Treatment is a process and subsequent visits may be necessary in order to achieve my desired results. I further acknowledge that no guarantees or assurances have been given to me by anyone as to the results that may be obtained from the Treatment.

I acknowledge that the Treatment has been explained to me and I have been provided with the necessary information for me to evaluate the risks and benefits of the Treatment. I have also received information regarding: (a) the nature and purpose of the Treatment and related care, treatment, services, medications, and/or interventions; (b) the potential benefits and possible risks, side effects and complications associated with the Treatment including potential problems that might occur during recuperation; and (c) the likelihood of achieving my desired results.

In addition, I understand that the Treatment may result in certain complications, including but not limited to: redness, swelling, irritation, pain, increased heart rate, increased bowel movements, and/or increased urination. These complications may vary in size and severity. Side effects may occur which have not been reported. I have been advised that, if I experience any unusual symptoms, to immediately report them to my doctor.

PATIENT INITIALS_____

Aftercare

I understand that it is recommended that I drink, at minimum, 1.5 liters of water on a daily basis when undergoing the Treatment. I further understand that it is encouraged that I complete a 30-45 min cardio workout after the Treatment. I acknowledge that any failure to follow these or any other aftercare instructions may compromise the final results of the Treatment.

PATIENT INITIALS_____

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Before, During and After Photo

I understand that during the Treatment, photographs or videos of the Treatment and/or of my appearance before and after the Treatment may be taken. These photographs will be used for treatment purposes including the assessment and evaluation of results; as well as may be used for the Practice's internal quality assurance or educational purposes.

PATIENT INITIALS_____

Media Authorization and Release

I understand that, by affixing my initials to this section, I authorize and give the Practice permission to use any photographs or videos of the Treatment and/or of my appearance before and after the Treatment (the "Recordings") for the Practice's public relations and marketing activities, including, in newsletters and on social media and the Practice's website. I understand that I may revoke this authorization at any time in writing, except to the extent that the Practice has taken action in reliance of this authorization. I understand that such Recordings may be available to third parties, or the public, and may be subject to redisclosure and no longer subject to any privacy protection. I understand that the Practice will not receive any payment in exchange for the use or disclosure of the Recordings. I agree that any Recordings shall be the property of the Practice.

I hereby release, waive and forever discharge any and all claims, causes of action, damages, liabilities and obligations that I may have or later assert against the Practice in connection with or related in any way to: (a) the Recordings; or (b) the use or disclosure of the Recordings or any portion of it.

I understand that I may refuse to sign this section and that my ability to receive the Treatment will not be affected if I do not sign this section.

PATIENT INITIALS_____

I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

_____ _____

Signature Date

_____

Print Name

PRACTITIONER'S CERTIFICATION

I hereby certify that I have explained to the patient (a) the nature and purpose of the Treatment; (b) the potential benefits and possible risks, side effects and complications associated with the Treatment, including potential problems that might occur during recuperation; and (c) the likelihood of achieving patient's desired results. I believe that the patient understands what I have explained and answered. I hereby confirm the accuracy of the document including the description of the Treatment.

Practitioner _____

Signature Print Name Date