Neroli
Institute

☐ 6051 Arlington Blvd, Suite B,
Falls Church, VA 22044
703.241.2173

☐ 1880 Howard Ave, Suite 203
Vienna, VA 22182
703-356-6143

HEALTH HISTORY INFORMATION

LIPO AND DUAL LIPO LASER

NAME **Today's Date:**

LAST: **FIRST:** **M.I:**

HOME ADDRESS:

DATEOF BIRTH: **AGE:** **Sex:** **Female** ☐ **Male** ☐

HOME PHONE: **CELL PHONE:**

EMAIL:

I consent to this email address to be added to the Med Spa and will be used to send email and newsletter, where I will get information on specials and promotions. Yes ☐ **No** ☐

LEAVE MESSAGES AT: Home ☐ **Cell** ☐ **Email** ☐

OCCUPATION:

PRIMARY CARE PHYSICIAN|PHONE NUMBER:
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? [name and phone]

UNLESS OTHERWISE INDICATED, WE HAVEPERMISSION TOCOMMUNICATE CHANGES IN YOUR HEALTH STATUS, INCLUDING SURGERY, TO OTHER PHYSICIANS PARTICIPATINGIN YOURCARE.
Yes, May Notify ☐ **No, Please Do Not Notify** ☐

DOYOU HAVE ANY MAJORMEDICAL PROBLEMS, SERIOUS ILLNESS? Yes ☐ **No** ☐
IF SO, PLEASE LIST:
PLEASE LIST ALL PRIOR SURGICAL PROCEDURES ANDDATESPERFORMED:

PLEASE LIST ALL INJECTABLE PROCEDURES {Botox, Jevederm, Restylane, Collagen, etc.} AND DATES PERFORMED.

MEDICAL HISTORY

DO YOU HAVE APACEMAKER OR DEFIBRILLATOR?..... ☐

DO YOU SUFFER FROM "PHOTOSENSITIVITY" {EXTREME SENSITIVITY TOSUNLIGHT} ..... ☐

DO YOU HAVE A HISTORY OF EASY/EXCESSIVE HYPERPIGMENTATION?..... ☐

DO YOU FORM KELOID SCARS?..... ☐

DO YOU HAVE ANY METAL IMPLANTS?..... ☐

DO YOU WEAR CONTACT LENSESES?..... ☐

HAVE YOU TAKEN ACCUTANE, RETIN A, OR RENOVA IN THE PAST 12MONTHS?..... ☐

ARE YOU CURRENTLY TAKINGCOUMADIN [Warfarin]OR OTHER BLOOD THINNERS?..... ☐

DO YOU REQUIRE ANTIBIOTICS BEFORE PROCEDURES SUCH AS DENTAL CLEANINGS?..... ☐

DO YOU SMOKE? Yes ☐ No ☐ IF YES, HOW MANY PACKSPER DAY?

DO YOU DRINK ALCOHOL? Yes ☐ No ☐ IF YES, QUANTITY PER WEEK?

HAVE YOU EVER HAD AN ADVERSE REACTIONTO LASER OR COSMETIC TREATMENTS?
Yes ☐ No ☐ IF SO, PLEASE LIST:

ARE YOU ALLERGIC TO ANY MEDICATIONS?..... ☐
IF SO, PLEASE LIST:

DO YOU HAVE ANY OTHER ALLERGIES?..... ☐
IF SO, PLEASE LIST:

DO YOU TAKE ANY OF THE FOLLOWING **[Please check]:**

- ☐ **all that apply and/or list additional medications**
- ☐ **ANTI-COAGULANTS**
- ☐ **ANTI-DEPRESSANTS**
- ☐ **APPETITE DEPRESSANTS**
- ☐ **ASPIRIN OR IBUPROFEN**
- ☐ **BLOOD PRESSURE MEDICATION**
- ☐ **CORTISONE OR STEROIDS**
- ☐ **ANTIBIOTICS**
- ☐ **HORMONES/CONTRACEPTIVES**
- ☐ **NSULIN**
- ☐ **NSAIDS**
- ☐ **SEDATIVES**
- ☐ **THYROID MEDICATION**
- ☐ **OTHER**

ARE YOU TAKING HERBAL PREPARATIONS OR VITAMINS [St. JohnsWort, Vitamin E, etc.]? **Yes** ☐ **No** ☐
ARE YOU OR MIGHT YOU BE PREGNANT?..... **Yes** ☐ **No** ☐
ARE YOU TRYING TO BECOME PREGNANT?..... **Yes** ☐ **No** ☐
ARE YOU NURSING?..... **Yes** ☐ **No** ☐

HAVE YOU EVER HAD ANY PROBLEMS WITH ANY OF THE FOLLOWING ANESTHETICS? IF SO, PLEASE SPECIFY:

- ☐ **BLOCK [e.g., dental]: Ineffective |Heart palpitations |Systemic reaction| Other:**
- ☐ **LOCAL: Ineffective |Heart palpitations |Systemic reaction| Other:**
- ☐ **TOPICAL: Ineffective |Heart palpitations |Systemic reaction| Other:**

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING [Please check all that apply]:

- ☐ **Active Infection**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bleeding Disorders**
- ☐ **Blistering Sunburns**
- ☐ **Circulation Problems/Blood Clots**
- ☐ **Cold Sores/Shingles**
- ☐ **Collagen Disorders**
- ☐ **Diabetes (Type__)**
- ☐ **Easy Bruising**
- ☐ **Endocrine/Hormonal Issues**
- ☐ **Eye Problems**
- ☐ **Fatigue**
- ☐ **Fibromyalgia**
- ☐ **Headaches/Migraines**
- ☐ **Heart Condition**
- ☐ **Hepatitis**
- ☐ **High/Low Blood Pressure**
- ☐ **Other**
- ☐ **Hormonal Imbalance**
- ☐ **Insomnia/Sleeping Problems**
- ☐ **Joint Injury**
- ☐ **Multiple Sclerosis**
- ☐ **Muscle Pain/Spasms**
- ☐ **Neurological Disorders**
- ☐ **Permanent Makeup/Tattoo**
- ☐ **Pigmentation Disorders**
- ☐ **Psoriasis**
- ☐ **Melanoma**
- ☐ **Scleroderma**
- ☐ **Skin Cancer**
- ☐ **Skin Injury**
- ☐ **Stroke**
- ☐ **Unusual Moles**
- ☐ **Varicose Veins**
- ☐ **Vision Deficits**
- ☐ **HIV/AIDS**

SKIN CARE HISTORY AND CONCERNS

PLEASE LIST ANY PRODUCTSTHATIRRITATEYOUR SKIN:

HAVE YOU HAD UNPROTECTED SUN EXPOSURE OR BEEN IN A TANNINGBOOTH IN THE LAST 2 WEEKS? Yes ☐ No ☐

DOYOU USE SELF TANNERS? Yes ☐ No ☐ IF YES, WHEN WAS THE LAST APPLICATION?
ARE YOU PLANNING A VACATIONIN THE SUN IN THE NEXT 3-6MONTHS? Yes ☐ No ☐

HAVE YOU USED ANY OF THE FOLLOWING HAIR REMOVAL METHODS IN THE PAST6WEEKS?
SHAVING ☐ WAXING ☐ ELECTROLYSIS ☐ PLUCKING/TWEEZING ☐ STRINGING ☐
EPILATORIES ☐
PLEASE INDICATEYOUR CURRENT SKIN CARE PRODUCTS/REGIMEN:

THERAPIST/PROVIDERREVIEWED: SIGNATURE _____ DATE_____
THERAPIST PRINTED NAME:

Neroli
Institute

LIPO & DUAL LIPO LASER AND EMS CONSENT FORM

Lipo Laser and Dual Lipo Laser are technologies for breakdown of the fat deposits. These procedures do not involve invasive surgery. There is no need for anesthesia, hospital stay and no down time. They provide a non-invasive method to break down stubborn fat deposits that never seem to disappear no matter what your diet is or how hard you exercise. The most problematic body areas are abdomen, flanks (love handles), inner thighs, buttocks, inner knees, under chin and upper arms.

Appointments are usually scheduled 2-3 times per week. In order to ensure maximum results, it is necessary to follow the recommended treatment schedule. The total number of treatments will vary between individuals. **On occasion, there are patients that do not respond to treatments.** I understand the nature, goals, limitations, and possible complications of this procedure and have discussed alternative forms of treatment. I have had the opportunity to ask questions and discuss the procedure as well as any limitations, complications and/or side effects.

I have read, understand, and agree to the following:

The goal of any treatment, as in any cosmetic procedure, is improvement, not perfection, and results may not be perfect due to any genetic, hormonal, nutritional, or topical applications interference or an impact of unpredictable reactions.

Occasionally, **unforeseen mechanical problems** may occur, and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

Do not accept advice from anyone not directly responsible for your post care. Suggestions from friends may be sincere but are often not helpful or even innocently harmful. **Compliance with the aftercare guidelines is crucial.**

In rare cases, allergies reactions to tape, preservatives used in cosmetics, topical preparations, etc., have been reported. Systemic reactions (which are more serious) may result from prescription medicines.

Should you have any concerns or questions, please do not hesitate to call our office. Our main goal is client satisfaction. That is why is VERY important to fully educate our client on the procedure(s) so they will have understanding, trust and confidence in their decision.

Signature: _____

Neroli
Institute

LIPO & DUAL LIPO LASER AND EMS CONSENT FORM

I understand that the physician or technician can decide if treatment is NOT appropriate for any of the following reasons:

- **Medications**
- **Extreme sensitivity or allergic reactions in the treated area**
- **Cutaneous lesions**
- **Presence of metallic prosthesis**
- **Metal plates in your body**
- **Medical plastic parts or parts containing metal**
- **Pacemaker, high blood pressure or heart problems**
- **Numbness or insensitivity to heat**
- **Abnormal immune system**
- **Acute inflammatory processes**
- **Proximity of the organs to the bone marrow**
- **Pregnancy or breastfeeding**
- **Epilepsy**
- **Tumors or cancer**
- **Gall stones**
- **Kidney damage, liver damage or diseases**
- **Active infections, hives, herpetic lesions or cold sores**
- **Hemorrhagic disease, clotting or bleeding**

If I have misled the physician, technician, or student for any of the reasons listed above, by signing below, I fully understand and take responsibility for any post-treatment consequences.

24 HOUR CANCELLATION POLICY

Confirmation of your appointment is a courtesy call, not an obligation. It is the clients full responsibility to keep track of his/her scheduled appointments. If a client fails to notify of appointment cancellation at least 24 hours in advance, the no-show will be counted as a used treatment of the client's package deal, or a $40.00 cancellation fee must be paid to accommodate the licensed technician's time. For any credit card payments, a 10% surcharge and merchant fee will be deducted in case of any refunds 14 days after the original transaction.

PACKAGE REFUND POLICY

By signing this No Refund Policy, I am agreeing that any service(s), service package(s), gift certificate(s), and/or retail product(s) purchased at Neroli Med Spa is a final sale. I understand any and all service(s), service package(s), gift certificate(s), and/or product(s) purchased will not be refunded or issues a credit. I also understand that if I decide to cancel or postpone any service(s), service package(s), gift certificate(s), and/or retail product(s), I will forfeit all monies paid; including any deposits and/or payments I have already paid.

Neroli
Institute

LIPO & DUAL LIPO LASER AND EMS CONSENT FORM

[PLEASE INITIAL BELOW]

_____ **I have provided my past and current medical history and medications.**

_____ **I am not pregnant or nursing.**

_____ **I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the information given to me.**

_____ **Contraindications to the performance of this procedure have been discussed in detail with me.**

_____ **I hereby release all related staff from all liabilities associated with the above-indicated procedure(s).**

_____ **I consent to the taking of photographs for medical education and/or marketing purposes. I understand my name will not be used to identify these photographs.**

_____ **I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.**

_____ **I have read and understood all information presented to me before signing this consent form.**

By signing this form, I am giving NEROLI MED SPA permission to treat me, and I understand all symptoms and side effects that may occur during or after treatments, thereby releasing NEROLI MED SPA of all liability regarding these issues.

I acknowledge being given a copy of this Agreement on the date signed.

Signature: Date: / /

Print Full Name:

Refund , Return and Cancellation Policy

As a courtesy to other Spa guests and our therapists, please give at least a 48-hour notice of cancellation to avoid a $25 charge or as a penalty one of your sessions taken away. A credit-card number , advanced payment, or gift-certification number may be required at the time of booking. For spa packages and two or more guests coming together we require a 48 - hour cancellation notice. Groups and bridal parties will require a 50% deposit at the time of booking. A refund is not available after you have used a portion of the services you booked.After one session the fee for package of two is non-refundable.Please ask new update of our staff about our refund and return and cancellation policy.Educational programs After two sessions the fee for programs is non-refundable.We do not provide refunds for cancelled or missed appointments.

Signature: _____ Date: / /

Print Full Name: _____