LipoLaser Treatment and Consent

I, _____ duly authorize the technicians of Ifeanyi O. Obianyo, M.D. to perform iLipo and/or the Lipo-Light procedure(s) for the purpose of fat spot reduction and improving the appearance of cellulite. I am aware that clinical results may vary depending on individual factors, including medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. I have been made aware that my diet and the amount of exercise I do, will have a major effect on the results of my treatments. If I do not make an effort to address my dietary and exercise, I am aware that the results achieve may not be retained.

I understand that laser body contouring involves a course of treatments and all sales are final. Services and treatment packages are non-refundable and non-transferable. The fee structure has been fully explained and I understand that I am required to pay for a course of treatments prior to any procedures taking place. I am fully aware that should I wish to cancel the course, the outstanding treatment value is non refundable. For your convenience, we accept cash, Visa, Maser Card, and Discover.

The course cost is $_____ for _____ treatment sessions.

Patient's initials: _____

Due to the demand for treatments, we schedule all 8 appointments following the initial consultation. Please be aware that all cancellations require a minimum of 24hrs notice. Failure to do so will result in that treatment being deducted from your course without a refund. It is important to be aware that this may have a negative affect on your overall results. Any changes to the initial treatment dates will be subject to availability.

Ensure Your Best Results

- Drink plenty of water after every treatment
- Incorporate Whole Body Vibration post treatment for 10 minutes
- Ensure you undertake physical activity following each treatment to maximize your results
- Manage calorie intake; excess calories will counter act the Laser Treatments
- Alcoholic beverages and high sugar content drinks must be avoided

My signature below constitutes my acknowledgment that. I am a competent, consenting adult of at least 18 years of age (or my parent or legal guardian is giving consent on my behalf), and further, that I:

- Have read and understand the information provided in this form;
- Have had my procedure adequately explained to me by my clinician;
- Have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction;
- Have received all of the information I desire concerning my procedure;
- Understand all post treatment recommendations and agree to adhere to them;
- Freely assume any risks of complications or injury from known or unknown causes associated with, relating to, or otherwise arising out of this procedure;
- Have the right to consent to or refuse any proposed procedure at any time prior to its performance;
- If I have a tattoo in the treatment area, there is a risk, although slight, that if the tattoo was not put on deep enough in the dermis or it is new, the tattoo may bleed or blister. Please notify us of your tattoo and your decision on treatment.
- Must notify the clinician if my medical history changes prior to subsequent treatments;
- Consent to photographs of the treatment area. There will not be a face or a name with the photos.

I understand that with some skin types, there is a risk of temporary redness and/or discoloration of the skin localized in the treatment area that can last up to several hours. There is also a possibility of tattoo lightening if located in the treatment area.
I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes, and possible complications. I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of a cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I, _____ consent to, and authorize Ifeanyi O. Obianyo, M.D. to perform laser treatment for _____ area(s) for body contouring and I agree to comply with recommendations for optimal results.

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____/_____/ _____

A photocopy of this consent shall be considered as valid as the original.