Required Physician Statement

DATE _____

Name: _____ D.O.B. _____

Address: _____ Telephone: _____

Please confirm that the above-named client doesn't have any health condition that you would advise against having a non-surgical lipo laser and ultrasonic cavitation and 20-30-minute light physical exercise.

YES ____ **NO**____

Please indicate if the client is with any of the following and any concerns or precautions with receiving the above listed services.

1) Pregnancy _____
2) Thyroid cancer _____
3) Abnormal immune system, immune suppressed _____
4) Heart disease or configured cardiac Pacemaker _____
5) Hypersensitivity to heat _____
6) Uncontrolled high blood pressure _____
7) Deep vein thrombosis _____
8) Hemorrhagic diseases, trauma or who is bleeding _____
9) Acute inflammation, asthma, chronic inflammatory diseases _____
10) Artificial parts such as implants, such as metal teeth or silicone _____
11) Numbness in target area * Physician please indicate any area of numbness _____

_____

_____

Client please indicate treatment area _____

_____

_____ _____

Print Physician name Physician Signature

_____ _____

Print Client name Client Signature

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