Lipocavitation Consent

I understand that Lipocavitation is a non-invasive treatment which aids in the reduction of localized fat deposits.
*Using ultrasound waves, Lipocavitation is ideal for people seeking fat removal from a specific area such as the hips, thighs, buttocks, stomach or arms and a more contoured shape.*_____

*I understand that this treatment does not interfere with adjacent structures such as blood vessels and nerves and therefore is completely safe, but factors do take place if you have a pacemaker, cancer, Diabetes, High Blood Pressure and more. These factors have been fully explained to me.*_____

*I understand that clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.*_____

*I understand that Lipocavitation involves a series of treatments and fee structure has been fully explained to me.*____

*I confirmed that I have informed the staff regarding any current or past medical condition, disease or medication taken.*_____

*I consent to have my photographs taken and authorize their anonymous use for the purpose of medical audit, education and promotion.*_____

I acknowledge and agree that Lady Bella Med Spa is providing these Lipocavitation treatments to me subject to my express consent to be bound by Lady Bella Med Spa refund policy as evidenced by my signature herein below.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of both this consent form and those of Lady Bella Med Spa refund policy.

*Patient Signature:*_____*Date:*_____

Witness: _____*Date:*_____

VelaShape Consent

I authorize Lady Bella Med Spa to perform VelaShape Treatment.

I understand that VelaShape uses combined energies the vacuum and tissue manipulation evens out the skin to reveal a smoother known as Elos to precisely target and heat fatty tissues within the treatment area. In addition, the vacuum and tissue manipulation evens out the skin to reveal smoother figure. _____

I understand that VelaShape is a device used for improving the appearance of cellulites and it may also be used as therapeutic for improving circulation and muscle aches as reddening, blistering, scabbing, temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me._____

I understand that clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment and that gradual improvement of the treated area can be seen following the first treatment - with the skin surface of the treated area feeling smoother. Results in Circumference and Cellulite Reduction will be most apparent 6-8 weeks following the final treatment session._____

I understand that treatment involves a series of treatments and fees structures has been fully explained to me._____

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final results obtained. I am fully aware that my condition is of cosmetic concern and the decision to proceed is based solely on my expected desire._____

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

I consent to have before and after photographs taken and authorize their anonymous use for purpose of medical audit, education and promotion.

I acknowledge and agree that Lady Bella Med Spa is providing these VelaShape treatments to me subject to my express consent to be bound by Lady Bella Med Spa refund policy as evidenced by my signature herein below.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of both this consent form and those of the Lady Bella Med Spa Refund policy.

Patient Signature: _____ **Date:**_____
Witness: _____ **Date:**_____