

Patient	Provider

This consent to treatment form explains the risks and benefits of the Contour Light treatments. Patient understands the following:

1. Results vary greatly from person to person. No result is guaranteed.
2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.
3. Temporary hyper pigmentation/hypo pigmentation (changes in skin color) on rare occasion may occur as a result of treatment.
4. Contour Light should not be used by patients with any of the conditions listed below.

**Conditions that Prevent Treatment**

Patient agrees (by initialing) that all of the following are true:

\_\_\_\_\_ I am over the age of 18

\_\_\_\_\_ I do not have and never had any of the following medical conditions:

- Cancer (active or within 1 Year of remission)
- HIV/AIDS
- Hepatitis C or D
- Uncontrolled High Blood Pressure

\_\_\_\_\_ I am not pregnant or breastfeeding

\_\_\_\_\_ I do not have a pacemaker

**SIGNATURE**

By signing below, patient agrees that provider listed above may perform the Contour Light procedure for the purpose of body contouring. Patient understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of patient's knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**DISCLOSURE TO THIRD PARTIES (OPTIONAL)**

By signing below, patient agrees to permit provider and third parties authorized by provider to use patient's name, photos and/or videos in the marketing of the Contour Light system and procedure. Absent a signature, provider will not disclose patient's identity to any third party except as required by law.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_