

RENA Sculpt Release

I understand that I may feel intense muscle contractions in the treated area, but I will have control over the intensity and length of the treatment. I can stop the treatment at any time for any reason. **Initials:** _____

I acknowledge that the treatment is preferably applied directly over the skin. If it is not, I am aware not to wear any **metallic** accessories (such as jewelry, watch or clothes containing metallic threads) and to **remove** my phone and wallet during the treatment. **Initials:** _____

Please circle any of the following you currently have or have had:

- Metal or electronic implants
- Cardiac pacemakers, implanted defibrillators, implanted neurostimulators
- Drug pumps
- History of abdominal surgery
- Pulmonary insufficiency
- Malignant tumor
- Metallic IUD
- Hemorrhagic conditions
- Heart disorders
- Epilepsy
- Recent surgical procedures (muscle contraction may disrupt the healing)
- Areas of the skin which lack normal sensation
- Current pregnancy or trying to get pregnant

If you circled any of these questions, please specify:

Please answer the following:

- Have you been pregnant? Y N
 - Have you had a C-section? Y N
 - Have you had a Vaginal birth? Y N
- _____

Treatment considerations

- I am aware that the treatment cannot be applied over the head, heart, or neck and that I should notify my therapist if I would like the paddles moved. **Initials:** _____
- I am aware that pregnancy and nursing are contraindicated, and pregnant women cannot undergo the treatment. **Initials:** _____
- I understand that there are certain risks associated with Renasculpt treatments and they include but are not limited to muscular pain, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness. **Initials:** _____
- I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. **Initials:** _____
- I have read the above information, and I request and give my consent to be treated with the Renasculpt by the practitioners in this practice and designated staff. **Initials:** _____

My signature below indicates that the above information is accurate and current.

Patient's signature: _____

Date: _____

Witness (in print): _____

Signature: _____ **Date:** _____

Practice Name: _____