SURNAME: _____

PERSONAL INFORMATION: PLEASE FILL OUT IN BLACK INK ONLY AND BLOCK LETTERS

DATE: _____ **THERAPIST:** Ellipse

FULL NAME: _____

ADDRESS IN FULL: _____ **POSTCODE:** _____

_____

E-MAIL: _____

MOBILE NUMBER: _____ **TEL. NUMBER:** _____

AGE: _____ **DATE OF BIRTH:** ____/____/____ **SEX:** M / F

HEIGHT: _____ **WEIGHT:** _____ **BMI:** _____

HOW DID YOU HEAR ABOUT VENUS MP^2?

_____

- **Which areas are you interested in treating?**

Full Face	
Neck/Jawline	
Upper Arms	
Stomach	
Upper Thighs	
Buttocks	
Breasts	
Other	

- **What are your goals and expectations of the treatment?**

_____

- **Have you ever had Radio Frequency in the past: YES / NO**
  If yes, please state what were your results:

_____

MEDICAL HISTORY*: Please carefully read through the following conditions and indicate Y/N if any applies.*

Heart Disease		**Eczema/Psoriasis**		**Fever**	
Pacemaker		**Herpes (or cold sores)**		**Vilitigo**	
Burns/Grafter Skin		**Pregnant/Planning Pregnancy**		**Roaccutane**	
Cancer		**Metal Implants**		**Mental Disease**	
Shingles/Chicken Pox		**Moles**		**Disorder of the thyroid gland**	
Fillers/botox in the last month		**Silicone implants**		**Telangicetasia**	
Facial laser resurfacing & deep chemical		**Medical conditions that impair healing**		**Open wounds**	
Epilepsy		**Keloid Scars**		**Actinic Keratozis**	
HIV/Aids		**Autoimmune Disease**		**Degenerative Neurologic Disease**	

Please specify to the following:

1. **Are you currently being treated for a condition not listed?** **Yes No**
   If yes, please specify_____

2. **Are you currently taking medication?**
   If yes, please specify_____

3. **Do you have any particular skin sensitivities or allergies?** **Yes No**
   If yes, please specify_____

4. **Have you had any major surgery performed in the last three (3) months?** **Yes No**
   If yes, please specify_____

5. **What products are you currently using on your skin, including body product?**
   _____

6. **Have you read and understood all the information given to you including all contra-indications?**

Date:_____ Signature:_____

INFORMED CONSENT – VENUS MP2 RADIO FREQUENCY

Venus MP^2 Radio Frequency treatment is a non-invasive method for:

- Anti Aging
- Circumferential Reduction
- Cellulite Reduction
- Skin Tightening

The purpose of the treatment is to achieve cosmetic improvements by using Radio Frequency & Magnetic Pulse technology. I understand that multiple treatments are necessary and may need to be performed in repeated sessions in the future to obtain optimal results.

Treatment with Radio Frequency (RF) and Magnetic Pulses (PMF) should not be painful and usually does not cause side effects. However it may cause temporary swelling and redness of the skin that will disappear in 1-2 hours. Please ensure that you **ALWAYS** inform your therapists to any change in your medical history prior to your appointment(s).

I hereby authorise **The Ellipse Clinic** to treat me using **Venus MP^2 Radio Frequency** for the purpose of inch loss / cellulite reduction / skin tightening / anti-ageing. I understand that the **Venus MP^2 Radio Frequency** is **NOT** to be used solely as a diet plan but that best results are achieved in **CONJUNCTION** with proper diet and exercise plan.

I agree that I have read the entire informed consent and I agree to all its provisions. I certify that I have had the opportunity to ask questions and these questions have been answered to my satisfaction. I fully understand the treatment condition and procedure.

I agree to pay £_____ for the above mentioned services and understand that there will be no refunds on any purchased treatments. However they can be exchanged to a different treatment or passed to another person.

_____

CLIENT SIGNATURE

_____ _____

PRINT NAME **DATE**

INFORMED CONSENT – Radio frequency with Magnetic Pulse.

The VENUS radio frequency treatment is a method of treating the following:

Facial anti-aging	Cellulite Reduction
Facial skin tightening	Body lifting
Body toning	Circumferential reduction

The above radio frequency treatment I wish to have is for _____.

The purpose of the treatment is to achieve **cosmetic skin improvements** by improving skin tone, collagen production, wrinkle reduction, skin tone and skin tightening. I hereby authorise Ellipse to treat me using the Venus System. I understand that treatment results may vary and that repeated sessions may be needed in the future to obtain optimal results and the treatment will not stop any cellulite/ loss of skin tone or wrinkles from re-occurring.

The areas to be treated are _____

I have been informed about alternative treatment possibilities and I understand that other forms of treatment or no treatment at all, are choices that I have.

I understand that there are certain risks associated with Venus Radio frequency treatment and they include but are not limited to the following:

- Post treatment discomfort like localised swelling, redness and mild tenderness.
- I understand that if I have not disclosed my medical history properly any issues that arise with my health I cannot hold ellipse responsible.
- I understand that should I have any adverse reaction or a pre-existing illness that is triggered by the treatment I cannot hold Ellipse Responsible.

Please ensure:

- All tattoos/semi-permanent make-up, beauty spots and raised moles are covered throughout treatment as this will prevent burns or scar tissue from forming.
- Please ensure that you always inform your therapist when there's been a change in health history and take note that this applies to starting a course of antibiotics, cortisone, steroids etc.
- Please ensure that you take an after-care sheet after **each performed** treatment.

I agree to follow the post treatment recommendations exactly in order to ensure the best possible results. I understand that **excessive heat should be avoided for 24 - 48 hours** after treatment. I agree to co-operate with the recommendations given to me regarding pre and post treatment care while I am under their care, realising that any lack of co-operation could result in less than optimum results. I agree to inform the above Clinic immediately if any adverse effects occur. I agree to photographic documentation of the treated area prior to treatment.

CLIENT SIGNATURE:_____PRINT NAME:_____

DATE:_____