

EMSCULPT^{neo}®

PATIENT TREATMENT RECORD

Patient's name:	Date of birth:
Phone:	Email:

You are scheduled for a series of non-invasive treatments with the EMSCULPT NEO®.

EMSCULPT NEO is indicated to be used for:

- Improvement of abdominal tone, strengthening of the abdominal muscles, development of firmer abdomen.
- Strengthening, Toning and Firming of buttocks, thighs, and calves.
- Improvement of muscle tone and firmness, for strengthening muscles in arms.
- Non-invasive lipolysis (breakdown of fat) of the abdomen.
- Reduction in circumference of the abdomen.
- Non-invasive lipolysis (breakdown of fat) of the thighs.
- Reduction in circumference of the thighs.
- EMSCULPT NEO is intended for use with skin types I – VI.
- Non-invasive lipolysis (breakdown of fat) of the flanks limited to skin types I - IV.
- Non-invasive lipolysis (breakdown of fat) of the upper arms limited to skin types II and III and BMI 30 and under.

The EMSCULPT NEO device is intended to be used under medical supervision for adjunctive therapy for the treatment of medical diseases and conditions.

The EMSCULPT NEO device is indicated for use in stimulating neuromuscular tissue for bulk muscle excitation in the legs or arms for rehabilitative purposes.

Indications for Use for Muscle Stimulators:

- Relaxation of muscle spasms
- Prevention or retardation of disuse atrophy
- Increasing local blood circulation
- Muscle re-education
- Immediate post-surgical stimulation of calf muscles to prevent venous thrombosis
- Maintaining or increasing range of motion

Initials: _____

THIS FORM IS ONLY A SAMPLE AND IS BEING PROVIDED TO BTL CUSTOMERS SOLELY FOR THE PURPOSE OF ENCOURAGING BTL CUSTOMERS TO DISCUSS THE USE OF SUCH A FORM WITH THEIR ATTORNEY. BTL INDUSTRIES DOES NOT REPRESENT OR WARRANT THE LEGAL SUFFICIENCY OR ENFORCEABILITY OF THIS SAMPLE CONSENT.

EMSCULPT^{neo}®

Please indicate your primary treatment goal:

- Sculpting
- Functional Wellness

Your treatment provider will discuss your specific treatment needs. The recommended number of treatments is four. Each treatment typically lasts about 20 to 30 minutes per session, with sessions separated by 5 to 10 days for the HIFEM+RF Advance/Gentle/Function preset or 2 to 3 days for the HIFEM Classic/Function preset. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on your goals.

Initials: _____

No unusual preparations are required before the treatment; however, it is strongly recommended to keep your body well-hydrated. On the day of the treatment, it's advisable to wear comfortable clothing that allows flexibility for proper positioning during the procedure. To prevent excessive sweating, the treatment area should be shaved or the hair trimmed beforehand. The treated area will also be wiped with alcohol wipes before the treatment to remove any moisture, perfume, moisturizers, or oils. You will be asked to remove all metallic accessories and electronic devices.

Initials: _____

I acknowledge that smoking, excessive alcohol consumption, eating disorders, and certain medications may affect the success of the treatment outcome. While no special diet is required, maintaining a healthy diet is encouraged to help promote and sustain results.

Initials: _____

The treatment does not require anesthesia. During the procedure, you may feel intense muscle contractions and a warming sensation in the treated area. It's important to note that while the warming sensation may be intense, it should never be painful. If you experience any pain or discomfort, please ask your provider to adjust the intensity. The procedure requires no recovery time, and you can typically return to your daily routine immediately afterward.

Initials: _____

THIS FORM IS ONLY A SAMPLE AND IS BEING PROVIDED TO BTL CUSTOMERS SOLELY FOR THE PURPOSE OF ENCOURAGING BTL CUSTOMERS TO DISCUSS THE USE OF SUCH A FORM WITH THEIR ATTORNEY. BTL INDUSTRIES DOES NOT REPRESENT OR WARRANT THE LEGAL SUFFICIENCY OR ENFORCEABILITY OF THIS SAMPLE CONSENT.

EMSCULPT^{neo}®

I am aware that I MUST NOT wear any metallic accessories (such as jewelry, watches, or clothing with metallic threads or accessories) during the treatment. I also confirm that I do not have any metallic or electronic implants (such as pacemakers, defibrillators, metallic IUDs, etc.).

Initials: _____

Please answer whether you currently have or had any of the following in the past*:

- Electronic implants (such as cardiac pacemakers, defibrillators and neurostimulators) YES NO
- Metal implants YES NO
- Drug pumps YES NO
- Malignant tumor YES NO
- Pulmonary insufficiency YES NO
- Muscles in acute phase of injury YES NO
- Cardiovascular diseases YES NO
- Disturbance of temperature or pain perception YES NO
- Hemorrhagic conditions YES NO
- Septic conditions and empyema YES NO
- Acute inflammations YES NO
- Systemic or local infection such as osteomyelitis and tuberculosis YES NO
- Contagious skin disease YES NO
- Elevated body temperature YES NO
- Pregnancy, postpartum and nursing period YES NO
- Graves' disease YES NO
- Metallic IUD YES NO
- Recent surgical procedures (muscle contraction may disrupt the healing) YES NO
- Areas of the skin which lack normal sensation YES NO

*For the full range of contraindications, warnings, and cautions, consult your treatment provider.

THIS FORM IS ONLY A SAMPLE AND IS BEING PROVIDED TO BTL CUSTOMERS SOLELY FOR THE PURPOSE OF ENCOURAGING BTL CUSTOMERS TO DISCUSS THE USE OF SUCH A FORM WITH THEIR ATTORNEY. BTL INDUSTRIES DOES NOT REPRESENT OR WARRANT THE LEGAL SUFFICIENCY OR ENFORCEABILITY OF THIS SAMPLE CONSENT.

EMSCULPT^{neo}®

If you answer YES to any of these questions, please specify:

Treatment considerations

- I am aware that the treatment cannot be applied over the head, neck, spinal cord, heart, or testes.

Initials: _____

- I am aware that the treatment cannot be applied over swollen or neoplastic tissues, space-occupying lesions, or skin eruptions.

Initials: _____

- I am aware that pregnancy is contraindication, and pregnant women cannot undergo the treatment.

Initials: _____

- I am aware that with any heat-based therapy, in rare cases, burns can occur.

Initials: _____

- I am aware that the applicators must always be in direct contact with the skin. **I am aware that treatment must not be applied over clothing or scar tissue.**

Initials: _____

- I understand that there are certain side effects associated with EMSCULPT NEO treatments. The side effects may include, but are not limited to muscular pain, intramuscular fat decrease, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness, increased menstrual flow in female patients and panniculitis.

Initials: _____

THIS FORM IS ONLY A SAMPLE AND IS BEING PROVIDED TO BTL CUSTOMERS SOLELY FOR THE PURPOSE OF ENCOURAGING BTL CUSTOMERS TO DISCUSS THE USE OF SUCH A FORM WITH THEIR ATTORNEY. BTL INDUSTRIES DOES NOT REPRESENT OR WARRANT THE LEGAL SUFFICIENCY OR ENFORCEABILITY OF THIS SAMPLE CONSENT.

EMSCULPT^{neo}®

- I understand that the treatment over muscles in the acute phase of injury is contraindicated.

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 agree to before and after treatment photographs, measurements, and weighing, as this will aid in the medical evaluation of the results of the treatment. This information will be collected for medical records or marketing purposes.

Initials: _____

- I understand results may vary from person to person and that an exact result cannot be predicted. Completing a full treatment series is necessary to maximize treatment efficacy. It is very unlikely, but I acknowledge that it is possible not to experience any noticeable results after the procedure. I understand that the results may not meet my expectations.

Initials: _____

- I certify that I have read this entire document and agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure, and possible side effects.

Initials: _____

- I have read the above information, and I request and give my consent to be treated with the EMSCULPT NEO by the physician(s) at this practice and their designated staff.

Initials: _____

THIS FORM IS ONLY A SAMPLE AND IS BEING PROVIDED TO BTL CUSTOMERS SOLELY FOR THE PURPOSE OF ENCOURAGING BTL CUSTOMERS TO DISCUSS THE USE OF SUCH A FORM WITH THEIR ATTORNEY. BTL INDUSTRIES DOES NOT REPRESENT OR WARRANT THE LEGAL SUFFICIENCY OR ENFORCEABILITY OF THIS SAMPLE CONSENT.

EMSCULPT^{neo}®

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

Patient's signature: _____ **Date:** _____

Witness (in print): _____ **Signature:** _____ **Date:** _____

Practice Name: _____

THIS FORM IS ONLY A SAMPLE AND IS BEING PROVIDED TO BTL CUSTOMERS SOLELY FOR THE PURPOSE OF ENCOURAGING BTL CUSTOMERS TO DISCUSS THE USE OF SUCH A FORM WITH THEIR ATTORNEY. BTL INDUSTRIES DOES NOT REPRESENT OR WARRANT THE LEGAL SUFFICIENCY OR ENFORCEABILITY OF THIS SAMPLE CONSENT.



Photo/ Video Consent Form

I hereby give permission for staff to take necessary clinical pre- operative and post operative photographs of me. I understand that such photographs are for confidential clinical records and that all photographs remain the property of the doctor.

Client Name

Client Signature

Date

Occasionally, such photographs are used for teaching purposes and for ethical publications for advancement and knowledge. In addition, they are occasionally used to give new clients indications of the possible results. I will permit the use of my photographs for the reasons stated above.

Please circle: Yes or No

Client Name

Client Signature

Date