6 STEPS
TO LIPO-LIGHT AND/OR LIPO-LIGHT PRO SUCCESS

OPTIMIZE YOUR LIPO-LIGHT AND/OR LIPO-LIGHT PRO RESULTS BY:

1. Maintaining your workout regimen. If you do not workout, walk for 30 minutes each day throughout your treatments to keep your lymphatic system moving.

2. Drinking a minimum of 64 ounces of water each day

3. As an added benefit, we recommend Biologique's new Griffonia & L-Tyrosine supplement, which aids weight loss by reducing cravings, helps ease anxiety and stress, and helps maintain normal blood sugar levels.

4. Reducing your fat intake, while increasing your lean proteins.

5. Eliminating alcohol and caffeine during your treatments.

6. Keeping your LIPO-LIGHT and/or LIPO-LIGHT PRO scheduled treatments, with no more than 72 hours between appointments. 48 hours is ideal.

EXTRAS TO HELP EVEN MORE!

- Wear spanks or support hose during the day
- Workout after treatment
- Receive one of our Biologique Body Slimming Treatments or Detox Treatments
  - helps with eliminating toxins and assists with lymphatic drainage
- Use of Vibration Plate (10 minutes) or NordicTrack (20 minutes)- West Haven Only
- For home maintenance we recommend the Biologique glove and a slimming oil to help eliminate toxins, fat and excess water. The Biologique Anti C creme or one of our other Biologique cremes will help with the appearance of orange peel skin and the glove and all accompanying products help to improve microcirculation.

HISTORY CARD
FOR LIPO-LIGHT AND/OR LIPO-LIGHT PRO LASER BODY CONTOURING

Name _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Email Address _____ How Referred _____
Previous Treatments [ ] Yes [ ] No Date Last Treated _____ Area _____

MEDICAL HISTORY

Are you under a doctor's care? _____
Recent surgery or injury? _____
Allergies: (ex. Latex, Foods, Medictions, Lidocaine) _____
Present Medications: _____
Present Herbal and Vitamin Supplements: _____
Any history of lymphatic disease? Yes [ ] No [ ]
Check all that apply to you:
[ ] hypo/hyper thyroidism, [ ] kidney disease, [ ] liver disease, [ ] currently pregnant, [ ] currently lactating

Date of Consult: _____
Height: _____
Weight: _____
BMI: _____
Positioning of Diode: _____
_____
_____
Notes: _____
_____
_____
_____
Followup Measurement Date: _____
Followup Measurement: _____

Date of 1st Measurement: _____
Price Quote 1: _____
Number of Sessions: _____
Payment: _____
Inches Lost: _____
Notes: _____
_____
Date of 2nd Measurement: _____
Price Quote 2: _____
Number of Sessions: _____
Payment: _____
Inches Lost: _____

Final Measurement Results: _____

SCHEDULE DATE AND TIME

1 _____	4 _____	7 _____	10 _____
2 _____	5 _____	8 _____	11 _____
3 _____	6 _____	9 _____	12 _____

Have you ever had any of the following? If yes, terminated [t] or continued [c]?

Heart Condition	[ ] Yes	[ ] No	Pacemaker	[ ] Yes	[ ] No
Cancer Treatment	[ ] Yes	[ ] No	Hepatitis (Type _____)	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No	HIV	[ ] Yes	[ ] No
Coagulation Problem	[ ] Yes	[ ] No	Keloids	[ ] Yes	[ ] No
Herpes I/II	[ ] Yes	[ ] No			

Patient Name: _____ Technician Name: _____

Patient Signature: : _____ Date: _____

NUTRITION INTAKE FORM

FOR LIPO-LIGHT AND/OR LIPO-LIGHT PRO LASER BODY CONTOURING

Please list the foods that you typically eat for each meal. Make sure to include foods that are not eaten frequently.

Breakfast: _____

_____

_____

Lunch: _____

_____

_____

Dinner: _____

_____

_____

Snacks: _____

_____

Dessert: _____

For each food class, please indicate how often you eat it. Write down how often you eat the items below.

Meat (beef, chicken, steak, turkey, ham, pork, luncheon meats): _____

Dairy (milk, cheese, yogurt, ice cream): _____

Eggs: _____ Bread: _____

Beans: _____ Fruit: _____

Fish (including tuna): _____ Salads: _____

Vegetables: _____ Nuts& Seeds (including peanut butter): _____

Rice: _____ Sweets (cookies, candy, cake, ice cream, etc.): _____

Cereal: _____ Pasta: _____

Tofu: _____

Please list how many 8 ounce cups per day or week

Water: _____ Juice: _____

Milk: _____ Coffee: (reg or decaf): _____

Tea: _____ Alcohol: _____

Soda: _____ Other: _____

Anti-Aging Centers
laser hair removal, cosmetic skin rejuvenation & esthetics

TREATMENT CONSENT FORM
FOR LIPO-LIGHT AND/OR LIPO-LIGHT PRO LASER BODY CONTOURING

I duly authorize the technicians of Anti-Aging Centers to perform the Lipo-Light and/or Lipo-Light Pro procedure for the purpose of body contouring, lymphatic drainage, improving the appearance of cellulite and skin tightening. I am aware that clinical results may vary depending on individual factors, including medical history, patient compliance with pre/post treatment instructions, and individual response to treatment. I have been made aware that my diet and the amount of exercise I do will have a major effect on the results of my treatments. If I do not make an effort to address my diet and exercise, I am aware that the results achieved may not be retained.

I understand that treatment by Lipo-Light and/or Lipo-Light Pro involves a course of treatments. The fee structure has been fully explained and I understand that I am required to pay for a course of treatments prior to any procedures taking place. I am fully aware that should I wish to cancel the course, the value of the outstanding treatments is non-refundable.

Due to demand for treatments, we schedule all appointments following the initial consultation. Please be aware that all cancellations require a minimum of 24 hours notice. Failure to do so will result in that treatment being deducted from your course without a refund. It is important to be aware that this may have a negative effect on your overall results. Any changes to the initial treatment dates will be subject to availability.

I certify that I have been fully informed of the nature and purpose of the Lipo-Light and/or Lipo-Light Pro procedure, expected outcomes, and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of a cosmetic concern, and that the decision to proceed is based solely on my expressed desire to do so. I am aware that Lipo-Light and/or Lipo-Light Pro may cause slight hypo/hyper pigmentation of the skin and treatment is taken at my own risk (tattoo areas should be avoided).

I understand that it is my personal responsibility to inform the therapist of any changes to my medical history during the course of treatment sessions, and I confirm that should this occur, I shall advise the therapist of any changes.

[ ] I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education, and promotion. (This is not required.)

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Name: _____

Patient Signature: : _____ Date: _____

Witness Signature: : _____ Date: _____

Anti-Aging Centers
laser hair removal, cosmetic skin rejuvenation & esthetics

CANCELLATION/NO SHOW POLICY

AAC understands that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another client from getting their much needed treatment. Conversely, the situation may arise where another client fails to cancel and we are unable to schedule you a visit, due to a seemly "full" appointment book! **If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 fee**

LATE CANCELLATIONS A late cancellation is considered when a client fails to cancel their scheduled appointment with a 24 hour advance notice.

NO SHOW POLICY A "no-show" is someone who misses an appointment without cancelling it with a 24 hour advance notice. A failure to be present at the time of a scheduled appointment will be recorded in your permanent profile record as a "NO SHOW."

*First missed appointment: there will be no charge

CREDIT CARD ON FILE POLICY At AAC, we require keeping your credit card or debit card on file as a convenient method of payment for no show fee.

Your credit card information is kept confidential and secure and the $25 cancellation fee will only be processed if AAC is not given the 24 hour notice as stated above. AAC will call to let you know of your missed appointment and that 24 hours after the missed appointment AAC will process the credit card authorized on file to be charged. If you have any questions or dispute please call within the 24 hours of missed appointment.

I authorize AAC (Anti Aging Centers of Connecticut, LLC) to charge $25 for a no show of my scheduled appointment 24 hours after the appointment to my credit card or debit card on file.
I, the undersigned, authorize and request AAC to charge my credit card on file $25 for a no show fee and agree this is my financial responsibility. This responsibility only relates to a missed appointment (no show fee).

Cardholder Name _____

Cardholder Signature _____