re:fit, p.c.
910 Waukegan Road
Glenview, IL 60025

Please type in the ields below on your computer
Client signs page 3x2

Name of Client: _____

Pressotherapy and/or Vacuodermie® Intake

Name _____ Age _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Preferred phone # ☐ Home _____ ☐ Work _____ ☐ Cell _____

What's the earliest/latest we can phone your home? _____

Email _____ Gender identity _____ Pronoun pref _____

Emergency Contact _____ Relation _____ Phone Number _____

Medical / Surgical History

I have or have had:

Deep vein thrombosis	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Acute infection of limbs	☐ Yes ☐ No	Hypothyroidism	☐ Yes ☐ No
Heart Failure	☐ Yes ☐ No	Presence of pain	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Numbness / loss of sensation	☐ Yes ☐ No
1st trimester pregnancy	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Severe eczema	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Coumadin	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Claustrophobia	☐ Yes ☐ No

Significant Disease _____

Circulatory Condition _____

Pregnancy History _____

Surgeries _____

Incisions _____

Current Medication _____

Birth Control / Hormonal Treatment _____

Allergies _____

Cosmetic Procedure History _____

Nutrition

Recent Weight Changes: Gain _____ Loss _____ Target Weight _____

Current Diet _____

Alcohol/Smoking _____

Physical Activity

Type _____ Frequency per week _____

# of minutes per session _____ How many months / years _____

re:fit, p.c.

Name of Client: _____

Client Consent for Pressotherapy and/or Vacuodermie® Procedure

I hereby request and authorize my practitioner _____ to provide and administer PRESSOTHERAPY/VACUODERMIE® procedure as it has been explained and described to me by _____.

I understand that Pressotherapy is a compression technique designed to improve overall circulation and tone the circulatory system for faster detoxification and elimination, fluid clearance, slimming and firming, toning and oxygenation. A computer controlled pump inflates the individual sections of the multichambered garment, which are positioned around the limbs. The pump inflates each chamber of the garment individually. I understand I should avoid Pressotherapy if I have any of its contraindications such as: infection, open wound, asthma, blood clots, first trimester of pregnancy, history of miscarriages, severe eczema, deep vein thrombosis, cardiac heart failure, or pacemaker. The treatment should not be administered when client is taking medications for the following conditions: heart, hemophilia, asthma, or high blood pressure, or taking steroid medications or Coumadin.

I understand that Vacuodermie® is a process of applying a vacuum to the skin through precise maneuvers utilizing cup sizes to match the surface of the treated body area. This non-invasive procedure actually stimulates the natural functions of the body and therefore remains both safe and comfortable while efficient and beneficial on many levels. The maneuvers lift the skin with the aid of suction. The purpose of this procedure includes scar and burn therapy, lymphatic drainage, contouring (including cellulite), oxygenation and an increase in metabolism and elimination of toxins.

Vacuodermie should be avoided if any of the following contraindications are present: any infection or pathology in their active phase, any acute or inflammatory disease, redness, bruises, hematomas, dematosis, infectious or mycotic disease, skin tumors, open wounds, vein thrombosis in its acute phase, fragile venous or lymphatic capillary system, recent fractures or bone grafts. The treatment should not be administered when client is taking medications for the following conditions: heart, hemophilia, asthma, or high blood pressure, or taking steroid medications or Coumadin. The details of the technique application have been depicted during the initial consultation in addition to written explanation as above. I am fully aware of the small risks to the treatment including the sensitivity reaction and minor bruising.

I understand the indications for use include secondary and primary lymph edema, post thrombosis edema, hypodermic inflammations, varicose or post thrombosis ulcers, lypodystrophy, face contouring and wrinkles. I have divulged all significant information regarding my medical history and answered all health related questions and will advise my practicioner of any changes in my health.

During the consultation, it was mentioned that the treatment results may vary from person to person and no guarantees have been made to me. All personal information in this Consent will remain strictly confidential and will not be disclosed without my consent in writing. I assume all risks involved and give consent for the duration of my treatment to all of the above described. I have asked my personal primary physicians any questions that I have concerning the Procedure and its risks. I understand that I am obligated to advise re:fit of any changes in my medical

Name of Client: _____

condition as long as I continue to receive the Procedure. I am aware that the Procedure may involve risks of injury. In consideration of re:fit's services in connection with the Procedure, to the fullest extent allowed by law, I assume the risk of any and all accidents, illness and injuries of any kind which may be sustained by me by reason of or in connection with my Procedure. In addition, I agree that, to the fullest extent allowed by law, neither re:fit nor any of its owners, agents, employees, personal representatives, successors, or assigns shall be liable or responsible for or on account of any such accident, illness, or injury, and I release, discharge, and absolve re:fit and its owners, agents, employees, personal representatives, successors or assigns from any and all liability and responsibility for or on account of any such accident, illness, or injury. To the fullest extent allowed by law, I shall indemnify, defend and hold harmless re:fit, its owners, agents, employees, personal representatives, successors, or assigns from any and all losses, liabilities, damage, costs and obligations (or actions or claims in respect thereof, including reasonable counsel fees), which I may suffer or incur, insofar, as such losses, liabilities, damages, costs or obligations (or actions or claims in respect thereof) arise out of or are based upon or are in any way connected with the Procedure.

This Agreement Consent shall be binding upon my heirs, legatees, personal representatives, successors and assigns.

My signature below indicates that I have read and understand this agreement and agree to be bound by it.

CLIENT SIGNATURE _____

PRINT NAME _____ DATE _____

Client Cancellation & Payment Policy - Pressotherapy and Vacuodermie®

Re:fit patients are seen by appointment only. Scheduling is based on a first-come first-served basis. To receive the full benefit of your session, please arrive on time. If you are going out of town or need to miss an appointment, please cancel any "standing appointments" as soon as possible.

Cancelling An Appointment With No Charge/ 24 Hours: To cancel an appointment with no charge we require *at least* twenty-four (24) hour notice. This notice must be given directly to re:fit by calling 847-657-0881. *Notice provided to a therapist is not sufficient.*
75% Cancellation Fee/ 6-24 Hours: If you call re:fit directly and cancel your appointment between 6-24 hours of the scheduled time, there will be a 75% fee of the visit's charge.
Full Price Cancellation/ 0-6 Hours or No Show: If you cancel less than 6 hours before your scheduled visit, or if you do not call to cancel an appointment, you will be charged the full price of the session.
Payment Policy: Payment is due at time of service.

Collection Action:
I, the undersigned, understand and agree that if collection action should become necessary for recovery of any monies due under services rendered or products purchased, I am responsible for any and all collection costs, court costs, and attorney fees. I also understand and agree that accounts with balances outstanding more than thirty days from the date of service or purchase will be charged a service fee of 5% per month of the outstanding balance, until the balance is paid in full.

By signing below, I agree to abide by the Cancellation and Payment Policies of re:fit, p.c.

_____ _____

CLIENT SIGNATURE DATE