



Aesthetic Wellness Center

Welcome to WellConsulted and the place to be to transform your body to health and wellness with our Doctor Designed body transformation protocol. At the completion of your initial visit today, you will meet with one of our Doctors, Nurses or a Health Coach to offer you an opportunity to further improve your health and wellness with our complete WellConsulted program of body transformation. Today you may receive the following:

- Consultation with one of our staff to answer questions you may have
- Consultation with one of our Certified Health Coaches or Doctor/Nurse
- Pre-Light Therapy body composition measurements
- Body Contour LED Light Therapy Session
- Vibration Plate Therapy Session
- Evolt Body Scan
- Hydro-Therapy Session

After completion of the above prepaid protocol our staff will review options available for you to improve your health and wellness through our non-invasive health and wellness aesthetic services. Our Doctor designed program is changing lives and we hope you are next to enjoy the benefits.

Check off which services are you are interested in learning about:

- Contour Light Therapy to reduce inches, weight and improve health
- InMode Evoke to reduce wrinkles and fat along cheeks and under chin
- Health and Wellness Coaching
- Chiropractic for Back or Neck pain
- Specific Spinal Decompression Therapy to reduce neck or back pain
- Botox and/or Jeuveau Injections
- Weight Loss Injections - Lipo Mix or Semaglutide
- Fillers
- PRP/Microneedling
- HRT (Hormone Replacement Therapy)

Please write or print clearly.

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Phone _____

Age _____ Height _____ Date of Birth _____

Current Weight _____ Ideal Weight _____

Married Y N Children Y N

Occupation _____

How did you hear about us?

Radio _____ TV _____ Magazine _____ Facebook/Social Media _____

Mailer _____ Friend _____ Other _____

Current Symptoms:

Please Check which apply:

| | | |
|-------------------|----------------------------------|-------------------|
| Fatigue | Diabetes | Self Confidence |
| Back Pain | High Blood Pressure | Herpes Simplex |
| High Cholesterol | Heart Disease | Sciatic Pain |
| Osteoarthritis | Gallbladder Disease | Shoulder Pain |
| Thyroid Disease | Gout | Upper Back Pain |
| Pulmonary Disease | Depression | Headaches |
| Anxiety | Spinal Arthritis | Joint Pain |
| Implants | Skin Cancer | Fibromyalgia Pain |
| Neck Pain | AIDS/HIV | |
| Acne/Eczema | Other Cancer - please list _____ | |

Other Serious illnesses? Please list:

Other health concerns:

Allergies _____

Are you happy with your energy level? _____

How often do you eat out each week?

Breakfast _____

Lunch _____

Dinner _____

How many alcohol beverages do you consume weekly? _____

Do you consume coffee? If so, what kind and how much do you drink daily?

Supplements or Medications currently taking - please list

On a scale of 1-10, 10 being completely committed and 1 just curious, what do you rate your level of commitment to improving your health and losing weight or tightening skin?

1 2 3 4 5 6 7 8 9 10

Are you committed to improving how you **LOOK** and **FEEL**? Y N

ADDITIONAL OPPORTUNITY to improve health

Many people who have weight concerns also have back pain concerns. With this understanding and with your prepaid promotion that you purchased, you are now eligible for a consultation and spinal examination with our Chiropractor for only \$99 when paid today.

_____ Yes, I would like to take advantage of this Spinal Examination offer today.

_____ No thank you.

WELLCONSULTED CLINICAL POLICIES

PATIENT CONSENT FOR WEIGHT LOSS THERAPY AND TREATMENT WITH WELLCONSULTED

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____ Services must be paid for at time of service. (Unless signed payment plan is on file)

_____ Health insurance typically does not cover services provided at WellConsulted. If you want to seek insurance reimbursement, we would be happy to provide you with itemized invoices that you can submit to your insurance company.

_____ I understand that treatments used at WellConsulted might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through health coaching, nutritional and supplemental counseling, and weight loss treatment.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or the emergency department.

_____ I acknowledge that WellConsulted is not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed at WellConsulted.

_____ I understand that there are no refunds for services or products rendered.

_____ I understand that having an appointment with WellConsulted does not necessarily entitle me to being issued a prescription for weight loss medication. Every individual is different, and it is at the medical director's discretion to issue a prescription.

_____ I understand that I must maintain my follow up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes.

_____ I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

I have read, understand and agree to all of the above statements.

Print Name: _____

Signature: _____ Date: _____

Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by WellConsulted: and their respective officers, directors, employees, stockholders, assigns, successors and affiliated (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by WellConsulted: rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by WellConsulted harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by WellConsulted. I am aware of the potential side effects associated with weight loss therapy, accept all the risks involved in taking the medication and will not seek indemnification or damages from the indemnified parties.

Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____