



**Miskell Medical LLC.**  
**218 W Madison St. Ottawa, Illinois 61350**  
**Phone: 815-431-1122 Website: www.miskellmedical.com**

### **Muscle Sculpting / Body Contouring Informed Consent**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ You are scheduled for a series of noninvasive treatments with the Muscle Sculpting Machine. The device is indicated for improvement of abdominal tone, strengthening of the abdominal muscles, development of firmer abdomen, strengthening, toning and firming of buttock.

\_\_\_\_\_ Your treatment provider will discuss your specific treatment needs. Recommended number of treatments is \_\_\_\_\_. The treatment is typically 30 minutes per session, with sessions separated by at least 2 days. Completing a full treatment series is necessary to maximize treatment efficacy. You may need additional treatments depending on your goals.

\_\_\_\_\_ Before the treatment, you are not required to do anything special, however, keeping your body well hydrated is recommended. On the day of treatment, you are advised to wear comfortable clothing which allows flexibility for correct positioning during the treatment. You will be asked to remove all metallic accessories and electronics devices.

\_\_\_\_\_ I acknowledge that a successful treatment outcome can be affected by smoking or excessive alcohol consumption, as well as: eating disorders or on-going medication. While no special diet is required you are encouraged to eat healthy to help promote and maintain results.

\_\_\_\_\_ The treatment does not require anesthesia. During the application, you will feel intense muscle contractions in the treated area. The procedure doesn't require any recovery time. Typically, you can get back to your daily routine right after the treatment.

\_\_\_\_\_ I acknowledge that the treatment should preferably be applied directly over the skin. If not, I am aware not to wear any metallic accessories (such as jewelry, watch or cloths containing metallic threads) during the treatment. I also acknowledge that I do not have metallic or electronic implants (such as pacemakers, defibrillators, metallic IUDs, ect.)

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

Metal or electronic implants:	YES	NO
Cardiac pacemakers, implanted defibrillators, implanted neurostimulators:	YES	NO
Drug pumps:	YES	NO
Pulmonary insufficiency:	YES	NO
Malignant tumor:	YES	NO
Fever:	YES	NO
Metallic IUD:	YES	NO
Sensitivity or allergy to latex:	YES	NO
Hemorrhagic conditions:	YES	NO
Injured or otherwise impaired muscles:	YES	NO
Heart disorders:	YES	NO
Epilepsy:	YES	NO
Recent surgical procedures (muscle contraction may disrupt healing):	YES	NO
Areas of the skin which lack normal sensation:	YES	NO

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

Please answer the following:



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⑩ Have you been pregnant? \_\_\_ C-section \_\_\_ Vaginal birth \_\_\_ Never Pregnant

⑩ Are you satisfied with the strength of your core muscles? YES NO

⑩ Are you satisfied with the shape of your body? YES NO

**Treatment considerations**

\_\_\_\_\_ I am aware that the treatment cannot be applied over the head, heart and neck.

\_\_\_\_\_ I am aware that pregnancy and nursing are contraindicated, and pregnant women cannot undergo the treatment.

\_\_\_\_\_ I understand that there are certain risks associated with Muscle Sculpting Machine treatments and they include but not limited to muscular pain, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness and intramuscular fat decreases.

\_\_\_\_\_ I understand that the treatment over injured or otherwise impaired muscles is contraindicated.

\_\_\_\_\_ I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks.

\_\_\_\_\_ I agree to before and after treatment photographs, measurements and weighing, as this will help for medical evaluation for the result of the treatment, Information will be acquired for medical records or marketing purposes.

\_\_\_\_\_ I understand the 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 it is possible that you will not feel any recognizable results after the procedure. I acknowledge the results may not meet my expectations.

\_\_\_\_\_ I certify that I have read this entire document and that I agree with all provisions. I certify that I 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.

\_\_\_\_\_ I have read the above information, and I request and give my consent to be treated with Muscle Sculpting Machine by the practitioner in this practice and her designated staff.

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

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Provider Name: Jessica Miskell, APN Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_