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

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The EMSCULPT NEO is intended for use on patients 18 and older to stimulate peripheral nerves for relief of chronic intractable pain, post-traumatic pain, post-surgical pain and/or for relief of chronic painful diabetic peripheral neuropathy in the lower extremities.

Initials: _____

Please indicate your primary treatment goal:

☐ Sculpting

☐ Function

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:** _____

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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

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- 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.

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: _____

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- 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: _____

- 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.

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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: _____

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

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

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

Practice Name: _____

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TREATMENT RECORD

Patient's name or ID: _____

Treatment area(s): _____

Age: _____

SESSION #	DATE	PRESET	TREATMENT TIME	HIFEM INTENSITY	RF INTENSITY	OPERATOR INITIALS
1						
2						
3						
4						
5						

COMMENTS: