

ReNue

411 Lakewood Circle Suite B127
Colorado Springs, CO 80910
Office: (719) 362-0735
www.ReNueMeNow.com

Laser Treatment Information and Consent Form

Welcome and Congratulations!

This form is designed to provide you with general descriptions of our various laser treatments, including possible risks and benefits that may occur as a result of these treatments. Please read carefully as this includes the **General Risks, Possible Risks, and Side Effects**. Risks and side effects may include pain, redness, swelling (edema), slight burning sensation, herpetic skin eruptions, hair reduction, skin discoloration, scar formation, and infection. A topical anesthetic may be applied before treatments to help alleviate some of these discomforts. Photographs are also recommended during treatment stages for future comparison. Multiple treatments will be necessary to achieve complete satisfaction. This is an important decision towards improving your wellness and overall lifestyle! We share the mutual desire of you reaching all of your goals involving laser treatment. In order for you to reach these goals, we have provided a few points to educate you on achieving your best results. It is important to manage your expectations according to an appropriate diet, lifestyle and exercise program incorporated in conjunction with your treatment protocol.

Procedures

Enhanced Skin Rejuvenation, Wrinkle Reduction, Vascular & Pigmented Lesions, Acne Treatment

Non-ablative (no body tissue removal) laser treatment is a technique used to improve skin texture and eliminate blemished areas from the skin. It is useful to counteract aging and sun damaged skin. The laser is designed to penetrate the lower layers of the skin without injuring the outer layers. Benefits include: reduction of fine wrinkles, pigmented lesions, solar spots, uneven skin color, and small red or blue vessels may be reduced or eliminated.

Permanent Hair Reduction & Pseudo folliculitis

Designed to target or destroy the hair follicle. Benefits include: delayed hair regrowth in the treated area, lightening of the hair, decreased density of the hair, and long term hair reduction. Multiple treatments will be needed to achieve satisfaction.

I-Lipo

Non-ablative laser treatment used to treat acne lesions on any part of the body. The laser penetrates the lower layers of the skin without harming the outer layers to reduce acne. Multiple treatments will be needed to reduce acne and the severity of lesions.

Treatment for Unsightly Veins

Varicose veins occur due to heredity, pregnancy, trauma, and the normal aging process. Depending on the size of the vein, laser treatment may be applicable. These veins are not necessary to the circulatory system and can be removed safely. Laser energy penetrates the vessels and generates heat, resulting in blood coagulation and vessel wall damage, causing it to collapse and be absorbed by the body.

TREATMENT INSTRUCTIONS

- Avoid the sun 1 week before and after your treatment.
- Avoid any topical medications or skin care products the day of treatment.
- You **MUST** avoid bleaching, plucking or waxing for 2-3 weeks prior to treatment.
- If you have had a history of perioral or genital herpes simplex virus, your medical provider may recommended prophylactic antiviral therapy. Follow the directions for your particular antiviral medication.
- If you have a tan or darker skin type a bleaching regimen may be started 4-6 weeks before a treatment. ***Recently tanned skin CANNOT be treated! If treated within 2 weeks of active tanning you may develop hypo-pigmentation (white-spot) after treatment. The use of self-tanning products must be discontinued one week before treatment.**
- Drink plenty of water after every treatment.

ReNue

411 Lakewood Circle Suite B127

Colorado Springs, CO 80910

Office: (719) 362-0735

www.ReNueMeNow.com

- Incorporate Body Vibration post treatment for 10 minutes after I-Lipo treatments.
- Ensure you undertake physical activity for at least 20 minutes following each treatment to maximize your results.
- Manage calorie intake; excess calories will counter act the laser treatments.
- Alcoholic beverages and high sugar content drinks must be avoided.
- The Laser is a device that produces an intense but gentle burst of light. The light is absorbed by the cause's selective heating of certain cells in your unwanted lesion. Lesions most commonly fade slowly over time as the destroyed cells are eliminated by normal body processes.
- My eyes will be covered with laser -specific safety eyewear or an opaque material to protect them from the intense light. My eyes will be closed and I will not attempt to remove the eye protection during treatment.
- I have been informed of the following possible risks and complications of this procedure.
- I understand that complete clearing may have possible risks and will depend upon the type, age and color of the lesion. Multiple treatments may be needed for the best results.
- Other methods of treating this condition have been discussed with me such that I may assess the risks and benefits of these alternative treatments methods.
- I understand that immediately following the laser treatment redness, swelling, discomfort, bruising, and discoloration may develop at the treatment site. I understand that any discoloration may last 7-14 days and swelling should resolve within several days.
- Discomfort may be treated with the application of cool compresses or topical soothing agents.
- It is important to follow after care instructions carefully to minimize the chance of incomplete healing texture changes or scarring. Sun avoidance and/or use of a sun block may be recommended. Tanning should be avoided.
- Have read and understand the information provided in this form;
- Have had my procedure adequately explained to me by my clinician;
- Have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction;
- Have received all of the information I desire concerning my procedure;
- Understand all post treatment recommendations and agree to adhere to them;
- Freely assume any risks of complications or injury from known or unknown causes associated with, relating to, or otherwise arising out of this procedure;
- Have the right to consent to or refuse any proposed procedure at any time prior to its performance;
- If I have a tattoo in the treatment area, there is a risk, although slight, that if the tattoo was not put on deep enough in the dermis or it is new, the tattoo may bleed or blister. Please notify us of your tattoo and your decision on treatment.
- Must notify the clinician if my medical history changes prior to subsequent treatments.
- **Initial: _____ Consent to photographs of the treatment area. There will not be a face or a name with the photos. I have provided my past and current medical history and medications.**
- I am not pregnant (female patients).
- I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the information given to me.
- Contradictions to the performance of this procedure have been discussed in detail with me.
- I recognize that laser treatments is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.

**Please keep the Instructions.

ReNue

411 Lakewood Circle Suite B127

Colorado Springs, CO 80910

Office: (719) 362-0735

www.ReNueMeNow.com

Name:		Sex: M / F	Birth Date:	Age:
		Height:	Weight:	Measurements:
Address:				
City:			State:	Zip Code:
Home:	Work:	Cell:	E-mail:	
Emergency Contact:				
Name:			Phone:	
Please put a check mark next to the procedures about which you would like to receive more information:				
<input type="checkbox"/> Enhanced Skin rejuvenation	<input type="checkbox"/> Skin Care Program		<input type="checkbox"/> Shaving Bumps/Ingrown Hair	
<input type="checkbox"/> Facials	<input type="checkbox"/> Acne treatments		<input type="checkbox"/> Broken Capillaries/ Rosacea	
<input type="checkbox"/> Wrinkles Reduction	<input type="checkbox"/> Sun Damage/Brown Spots		<input type="checkbox"/> Spider Veins/ Leg Veins	
<input type="checkbox"/> Laser Hair removal	Other			
Please put a check mark next to a past or current medical condition:				
Medical History:				
<input type="checkbox"/> Lupus or other auto-immune deficiency(A)	<input type="checkbox"/> Herpes simplex or fever blisters (A)		<input type="checkbox"/> Light sensitive Epilepsy (A)	
<input type="checkbox"/> Bleeding abnormalities (A)	<input type="checkbox"/> Rheumatoid Arthritis "Gold" Therapy (A)		Diabetes (A) <input type="checkbox"/>	
<input type="checkbox"/> Treatment with Accutane® in the last year (A)	<input type="checkbox"/> Currently Pregnant (A)		<input type="checkbox"/> Scars thatturn white or brown (A)	
<input type="checkbox"/> Treatment with Tetracycline® in the last month(A)	<input type="checkbox"/> Dark spots after pregnancy, skin injury (A)		<input type="checkbox"/> HIV (A)	
Tattoos/permanent make-up (A)	<input type="checkbox"/> Hirsutism (HR)		<input type="checkbox"/> Hepatitis (A)	
<input type="checkbox"/> Keloid or very thick scarring (A)	<input type="checkbox"/> Chemical Peels, Dermabrasion,)		<input type="checkbox"/> Waxing/Plucking/Electrolysis within last four weeks (HR)	
<input type="checkbox"/> Cystic Acne (P)	<input type="checkbox"/> Transplant Anti-Rejection Drugs (HR)		<input type="checkbox"/> Coumadin®/anti-clotting agents (A)	
<input type="checkbox"/> Leg ulcer or Phlebitis (V)	<input type="checkbox"/> Pulmonary embolism/blood clot (V)		<input type="checkbox"/> Blood thinning medication (V)	
<input type="checkbox"/> Psoriasis or Vitiligo (A)	Laser Resurfacing or Face Lift (A)		<input type="checkbox"/> Collagen injection (Location:_____)	
<input type="checkbox"/> Implants (Location:_____)	<input type="checkbox"/> Polycystic ovarian disease (PCOD)			
(For women) Last Menstrual Period:				
Are you currently pregnant?				
Have you had laser treatments in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO				
If yes, When? Where?				
Have you had any accidents or injuries, been hospitalized or had surgeries? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list:				
Please list any topical medications you are using:				
Do you have any implants/injectables/permanent make-up? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes?				
Do you have any tattoos? <input type="checkbox"/> YES <input type="checkbox"/> NO Is so, please list location:				
Are you involved in regular exercise or sports? <input type="checkbox"/> YES <input type="checkbox"/> NO				

ReNue

411 Lakewood Circle Suite B127

Colorado Springs, CO 80910

Office: (719) 362-0735

www.ReNueMeNow.com

If yes, please list type:		
List any chronic bodily discomfort that you have. <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe.		
Please describe your health condition(s) or any other concerns below:		
Have you ever had liposuction before? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list all areas:		
Do you have any known allergies? List any medication you may be allergic to: <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list example, latex, tape, penicillin, aspirin, sulfa, codeine, etc.		
Do you take Aspirin, Coumadin, Excedrin, Motrin or anything which thins the blood, including Vitamin E and Herbal Medications (Garlic, Ginger, Ginseng, Ginko)? <input type="checkbox"/> YES <input type="checkbox"/> NO		
List ALL Current Medications & Vitamins/Supplements in the last 6 months:		
Current Medical Problems:		
Please answer the following questions by circling the number which best describes you. Your clinician will total the score during the consultation.		
My ethnic origin is closest to:(check one)	I. Very fair (Celtic and Scandinavian)	
	II. Fair-skinned Caucasians with light hair and light eyes	
	III. Pale-skinned Caucasians with dark hair and dark eyes	
	IV. Olive-skinned (Mediterranean, some Asian, some Hispanic)	
	V. Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)	
	VI. Very dark-skinned (African)	
My eye color is:	Light blue	0
	Blue/green	1
	Green/gray/golden	2
	Hazel/light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light brown	2
	Dark brown	3
	Black	4
The color of my skin that is not normally exposed to sun is:	Pink to reddish	0
	Very pale	1
	Pale with a beige tint	2
	Light brown	3
	Medium to dark brown	4
	Dark brown-black	6
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when the burn resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
When was the last time that the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?	Longer than one month ago	0
	Within the past month	1
	Within the past two weeks	3
	Within the past week	4
Total Score:		
If your score is:	Your skin type is:	Notes:
0 – 3	I	
4 – 7	II	
8 – 11	III	
12 – 15	IV	
16 – 19	V	
20 – 24	VI	

ReNue

411 Lakewood Circle Suite B127

Colorado Springs, CO 80910

Office: (719) 362-0735

www.ReNueMeNow.com

Please indicate any parts of your body that you <i>do not</i> want to be treated:	Yes	No
Chin		
Scalp		
Face		
Neck		
Arms		
Hands		
Hips		
Under your eyes		
Forehead		

How did you hear about us? If friend please list name:					
What brings you here today?					
What results would you like from your sessions?					
Please circle the areas you are considering:					
Male Breast Reduction	Bra, Above	Abdomen, Upper	Thighs, Partial Inner	Upper Shelf of Buttocks	Back/Flanks
Arms (upper)	(Above the bra)	Abdomen, Lower	(Upper 4 inches)	Buttocks	Saddle Bags
Knees	Bra, Under	Love Handles	Thighs, Full Inner		
	(Under the bra)		Thighs, Front		
			Thighs, Back		
How much improvement in contouring and body change are you expecting?					
100%	80%-90%	60%-70%	40%-50%	20%-30%	10%-None
Mouth					
Muffin top					
Thighs					
Abdomen					
Upper Torso					
Back					
Buttocks					
Legs					
Feet					

Program and Background

You have requested to be treated with the Laser Lipo low-level laser therapy. This treatment is the application of a low intensity laser, which has been shown through extensive research to cause the fat within the adipocyte (fat cell) to leave the cell and accumulate in the interstitial space around the cells. In contrast to high power, high heat

ReNue

411 Lakewood Circle Suite B127

Colorado Springs, CO 80910

Office: (719) 362-0735

www.ReNueMeNow.com

lasers that are used in various procedures, the low level laser used for this treatment has no thermal effect on tissue. Instead, the non-invasive laser helps the body absorb fat by stimulating its biological function.

Excess fat is then removed naturally by the body's lymphatic system and subsequently excreted without the negative side effects and downtime associated with more invasive procedures such as liposuction. This therapy has been tested in several institutional review board approved studies in a double blind; placebo controlled fashion and found to be generally effective. Any medical or cosmetic procedure carries risk, complications and varied results as to the effectiveness of a particular treatment. The purpose of this document is to make you aware of the nature of this product and its risks in advanced so that you can decide whether to go forward with this procedure. Non-invasive low level laser therapy has been approved by the FDA.

Procedure

Initially you will consult with the CLS to determine if you are a candidate for low level laser therapy. During this time period you will have the opportunity to ask questions or voice concerns you may have concerning this treatment. If it is determined you are a candidate for this procedure, there will be a few preliminary steps consisting of: paperwork and measurements. Proceeding, the patient will need to expose the area to be treated and lie down. From here the treatment will be administered by placing 2-10 low level laser paddles on the desired area(s) to be treated. It is recommended that a patient will need a minimum of ten treatments for the low level laser to achieve its potential effect. This treatment should be used in conjunction with a healthy diet and exercise. If you are not currently exercising you should consult a health care professional before beginning an exercise program to determine if your body is physically able.

Risks/Discomfort

There are few risks associated with low level laser therapy. This treatment is non-invasive and uses a low level output laser. During treatment no discomfort will be present, the patient will not feel the laser, however the light will be visible.

***Please inform us if you think you are pregnant, or are unsure if you may be pregnant, as a pregnancy test may be required to proceed with treatment. Although no known detrimental risks exist, potential unknown risks may exist. If you have a pacemaker, this treatment may not be right for you. It is recommended that one does not treat directly over a pacemaker or its lead wires. No known risks exist, however potential unknown risks may exist. There are also a variety of other conditions for this treatment. It is possible that you may not see any improvement in your body shape or it may get worse. There also may be unknown risks associated with low-level laser therapy.**

Benefits

Over the years the benefits of low-level laser therapy have become more prominent. Low-level laser therapy has been used by chiropractors for pain management and recently by cosmetic surgeons to emulsify adipose before liposuction with FDA approval. The potential benefit of this treatment is body contouring without surgery. Problem areas or excess pockets of fat can be targeted, however the most commonly treated areas are the stomach, hips, flanks, and thighs. In clinical trials patients have averaged 4.5 inches lost from there stomach, hips, and thighs. These results do vary and no guarantee is implied or suggested that desired results will be achieved.

Alternatives

This is strictly voluntary cosmetic procedure. No treatment is necessary or required. Alternative treatments, which vary in sensitivity, effect, duration, and invasiveness include: liposuction, mesotherapy, lipo dissolve, vela smooth, dieting, exercise and potential others; which may have their own risks and benefits. You acknowledge this, and realize that the other option to you is do nothing.

Questions

ReNue

411 Lakewood Circle Suite B127

Colorado Springs, CO 80910

Office: (719) 362-0735

www.ReNueMeNow.com

By signing below, you certify that this procedure has been explained to you and your satisfaction. Any further questions can be directed to ReNue.

Consent

I have reviewed this consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form I grant authority for ReNue to perform the described treatment or administer any related treatment as deemed necessary or advisable for my medical condition. The purpose of this procedure, risks, complications, alternative methods of treatment has been fully explained to my satisfaction. Cosmetic indications for these procedures include but are not limited to cellulite reduction, treatment of problem fat areas, skin tightening, and skin rejuvenation. You may experience increased redness to the area for up to 12 hours. You will be able to return to most normal activities following the treatment.

I have been informed of the potential risks and side effects of laser lipo including but not limited to redness, swelling, heat sensitivity, pain, increase bowel movements, increased urination, increased menstrual flow and flu like symptoms. The nature of the proposed procedure, the risks, potential damages and adverse side effects has been explained to me and I fully understand. _____ Initial

I understand that a minimum of 10-16 treatments is required to achieve full results. At that point I will be re-evaluated to see if more sessions are needed in order to achieve realistic goals. Patients who are extremely thin may require fewer treatments, while heavier patients may require more. I understand the treatment is most successful if I also maintain a healthy diet and commit to an exercise program. I know that if after the treatment course I gain weight, the results of the laser treatments may be reversed. _____ Initial

No guarantee has been given by anyone as to the results that may be obtained by this treatment. I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information and feel I am sufficiently advised to consent to this procedure. I hereby give my consent to have this procedure.

- If at any time during the laser procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/ or terminate the session at my discretion.
- The undersigned assumes all responsibility for behavior of self and their clients and agrees to abide by all Rules and Procedures of the property.
- Clients are responsible for the completion and timely return of any client forms and payments, including but not limited to new client intake forms.

The clients and all persons on the premises by invitation of the clients' hereby hold **ReNue**, its employees, the corporation or any individual connected in any way to **ReNue** harmless for any responsibility or liability for any accident, injury illness or damages sustained by or to any person or their personal property during their treatment appointments or use of facilities. **ReNue** shall be indemnified and held harmless by the clients, and clients agree to pay all costs incurred in connection with any accident, injury illness or property damage loss, including attorney's fees, regardless of how it may have occurred.

The undersigned hereby releases and indemnifies **ReNue** and holds harmless any employee, the corporation or any individual connected in any way to **ReNue** for any loss of personal property and/ or accident causing personal injury of any nature, including reasonable attorney's fees and court costs in connection therewith. However, in the event of an occurrence, the client should inform our team members who will do everything within reason to rectify the problem. All information regarding the procedure is checked to ensure the accuracy of descriptions. However, we are not always able to control all of the components of the facility, city power outages, etc., and it is possible that an appointment time or procedure may become unavailable due to circumstances beyond our control and for which we do not accept liability. I further state that I am of lawful age and legally competent to sign this

ReNue

411 Lakewood Circle Suite B127
Colorado Springs, CO 80910
Office: (719) 362-0735
www.ReNueMeNow.com

forementioned release; I understand the terms herein is contractual and not a mere recital; I have signed this document of my own free act.

At **ReNue** we place the highest priority on the client's right to privacy. We recognize the added sensitivities for client's receiving body sculpting therapy. Our office staff is trained to protect our private health information, and our waiting areas are intentionally shielded and discrete. We value your privacy, and are committed to maintaining your security and confidentiality in the use of any information you choose to share with us. We do not disclose identifiable information to any third party without your consent. Further, we do not sell, rent, or otherwise allow the unauthorized outside use of personal information such as names, addresses, phone numbers, or e-mail addresses in our database without your permission. Copies of this form and signature will be valid as if original if this document is digitally scanned.

I have read and understood all information presented to me before signed this consent form. My signature below constitutes my acknowledgment that I am a competent, consenting adult of at least 18 years of age (or my parent or legal guardian is giving consent on my behalf), and further, that I authorize **ReNue**, to perform Laser/IPL treatments on:

(Print name)

Signature _____

Date: ___/___/___

***It is important to know; 100% certainty of success cannot be assured as with any medical procedure. It is also important to note that in the vast majority of cases patients achieve satisfactory results (supported by numerous clinical studies); in some cases results may vary and therefore not meet expectations of all patients completing a full series of treatments.*

FOR PATIENT'S WITH DIABETES:

If you ARE a *diabetic and take prescription medication for your diabetes, you MUST visit with your primary care physician for close monitoring of your medication and sugar levels while on a patient of ReNue. A signed release agreement from your physician must be provided for your file BEFORE you are accepted as a patient. Failure to do so will expel you.

Signature _____ Date ___/___/___

Print: _____

Patient Acknowledgement

Initial: _____ Because my CLS must be aware of any existing conditions that I have, I have listed all of my known medical conditions and physical limitations, and I will inform my CLS of any changes in my physical health. I understand that a CLS does not diagnose any medical, physical or mental disorder, prescribe medication or perform any spinal manipulations. In general, I understand that laser treatments are NOT medical procedures, are NOT for the purpose of stress reduction, relief from muscular tension/spasm, improving circulation and/or facilitating greater bodily awareness for optimal mind, body, spirit functioning. I am responsible for consulting a

ReNue

411 Lakewood Circle Suite B127

Colorado Springs, CO 80910

Office: (719) 362-0735

www.ReNueMeNow.com

qualified physician for any physical ailments that I might have. I freely assume any and all risks of treatment whether presently contemplated or hereinafter discovered.

Patient Name: _____

Signature _____

Notice of Privacy Practice Acknowledgement

Initial: _____ I understand that, under the Health Insurance Portability & Accountability Act of 1966 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practice.

“Individually identifiable health information” is information, including demographic data, that relates to: the individual’s past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number). If you feel your individual’s rights, including the right to complain or if you believe your privacy rights have been violated, you may contact the HHS directly.

Signature _____ Date ____/____/____

Print: _____

Cancellation Policy

ReNue’s mission is to provide our clients with an extraordinary experience by providing outstanding customer service in a comfortably convenient atmosphere. It is important to us that we see as many patients as possible in a timely manner. In order to accomplish this, we schedule the appropriate number of patients and a set time. That is our commitment and responsibility to you. We ask that, in return, you respect our time as well as other patients. If you cannot keep your appointment, you are required to CALL to cancel a minimum of 24 hours before your scheduled appointment. Cancellations will not be accepted through email or text messages. If the line is busy and you are directed to voice mail, please leave a detailed message with your name, phone number and type of service. All business must function with this understanding. Please honor this policy to avoid unnecessary charges.

Prepaid Patients: If a patient decides to cancel their treatment the day of, with the exception of having an emergency that prevents the treatment, the patient will forfeit the full payment for that scheduled treatment. Withholding medical information that could potentially harm or endanger the patient or the staff is against our medical and HIPPA policy and will result in the patient forfeiting all payments made in addition to permanently losing their

ReNue

411 Lakewood Circle Suite B127

Colorado Springs, CO 80910

Office: (719) 362-0735

www.ReNueMeNow.com

treatment availability. In addition, formal legal charges may be necessary pertinent to the potential harm caused to Longbrake Investments, Inc. There are no refunds for services rendered. All applicable payments must be made in advance of service. Cosmetic procedures are not covered by insurance; therefore, we may not accept any type of health insurance for any services at ReNue. Patients with Flexible Spending accounts will receive appropriate documentation to receive reimbursement from their employer.

Financial/Refund Policies and Patient Responsibility:

Initial: _____ There are no refunds for services rendered for our services. All applicable payments must be made in advance of service. We offer no payment plans.

Initial: _____ Health Insurance is not accepted by ReNue.

Initial: _____ Individuals with flexible spending accounts will receive appropriate documentation to receive reimbursement from their employer. Allow 5-7 working days for preparation. I attest that all the above information is true. I have also read and understand the refund / financial policies and patient responsibility mandated by ReNue.

Signature _____ Date ___/___/___

Print: _____

FOR PATIENT'S WITH DIABETES:

Initial: _____ If you ARE a *diabetic and take prescription medication for your diabetes, you MUST visit with your primary care physician for close monitoring of your medication and sugar levels while on a patient of ReNue. A signed release agreement from your physician must be provided for your file BEFORE you are accepted as a patient. Failure to do so will expel you from our program.

Signature _____ Date ___/___/___

Print: _____