

**THE
QUEENS INSTITUTE
FOR
SKIN DISEASE AND ANTI-AGING**

**Patient Information and Consent and Waiver
Form**

Pressotherapy Treatment

Patient Information:

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email: _____

Emergency Contact: _____

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Medical History:

Please check any conditions you currently have or have had in the past:

- Circulatory disorders (e.g., deep vein thrombosis)
- Heart disease or cardiac problems
- Hypertension (high blood pressure)
- Kidney disease
- Liver disease
- Skin infections or lesions in the treatment area
- Diabetes
- Pregnant or breastfeeding
- Recent surgery or injury
- Allergies (please specify): _____

Please provide any additional medical information that may be relevant to your treatment:

Description of Pressotherapy Treatment:

Pressotherapy is a non-invasive treatment that uses pneumatic compression to enhance lymphatic drainage and improve circulation. It involves wearing specialized garments attached to a machine that inflates and deflates with controlled pressure, aiding in detoxification and reducing swelling.

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Potential Benefits:

- Improved lymphatic circulation
- Reduction in fluid retention and swelling
- Enhanced detoxification
- Alleviation of cellulite
- Improved skin tone and texture

Potential Risks:

- Discomfort or bruising in the treatment area
- Aggravation of existing medical conditions (e.g., circulatory disorders)
- Allergic reactions to materials used in garments

Procedure:

During the treatment, you will lie comfortably while wearing the pressotherapy garments. The machine will be adjusted to your comfort level, gradually increasing and decreasing pressure to stimulate lymphatic flow.

Contraindications:

Pressotherapy may not be suitable for individuals with certain medical conditions. Please inform your therapist if you have any concerns or medical history that may affect your eligibility for treatment.

Waiver:

I hereby release and discharge The Queens Institute for Skin Disease and Anti-Aging, the Queens Med Spa, The Queens Health Centre, its staff, and affiliates from any and all claims, demands, causes of action, damages, or liabilities which may arise out of or in connection with the Pressotherapy treatment(s) provided, except those caused by gross negligence or willful misconduct.

I acknowledge that I have read and understand this form in its entirety, and I have had the opportunity to ask questions and receive satisfactory answers.

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Consent:

I have read and understand the information provided about pressotherapy treatment, including its benefits, risks, and alternatives. I have had the opportunity to ask questions, which have been answered to my satisfaction. I voluntarily consent to undergo pressotherapy treatment.

Patient's Signature: _____

Date: _____