3-WEEK LIPO LASER PROGRAM PROTOCOL

PATIENT NAME:	DATE STARTED THE PROGRAM:
Initial Evaluation	□ Paperwork doubled check for ALL information
	□ Take Symptom Survey at ClubReduce.com®
___ / ___ / ___	□ Close
	□ Products given and explained
	□ Food log explained
	□ Product form signed by patient and employee
	□ Contract and Disclaimer signed by patient and employee
	□ Verify next scheduled visit
VISIT 1	□ Evaluation
	□ Take "before" picture & beginning measurements
___ / ___ / ___	□ Lipo Laser treatment (40-50 minutes)
	□ Give first time patient complimentary hand facial during their first Lipo Laser appointment
	□ Whole Body Vibration (10 minutes)
	□ Sauna (20 minutes)
	□ Measure for inch loss
	□ Verify next scheduled visit
VISIT 2	□ Apply Heat to areas being treated by Lipo Laser
___ / ___ / ___	□ Lipo Laser treatment (40-50 minutes)
	□ Whole Body Vibration (10 minutes)
	□ Sauna (20 minutes)
	□ Verify next scheduled visit
VISIT 3	□ Apply Heat to areas being treated by Lipo Laser
___ / ___ / ___	□ Lipo Laser treatment (40-50 minutes)
	□ Whole Body Vibration (10 minutes)
	□ Sauna (20 minutes)
	□ Verify next scheduled visit
VISIT 4	□ Evaluation (Take half way measurements for inch loss)
___ / ___ / ___	□ Apply Heat to areas being treated by Lipo Laser
	□ Lipo Laser treatment (40-50 minutes)
	□ Whole Body Vibration (10 minutes)
	□ Sauna (20 minutes)
	□ Verify next scheduled visit
VISIT 5	□ Apply Heat to areas being treated by Lipo Laser
___ / ___ / ___	□ Lipo Laser treatment (40-50 minutes)
	□ Whole Body Vibration (10 minutes)
	□ Sauna (20 minutes)
	□ Verify next scheduled visit
VISIT 6	□ Apply Heat to areas being treated by Lipo Laser
___ / ___ / ___	□ Lipo Laser treatment (40-50 minutes)
	□ Whole Body Vibration (10 minutes)
	□ Sauna (20 minutes)
	□ Verify next scheduled visit
VISIT 7	□ Evaluation
	□ Apply Heat to areas being treated by Lipo Laser
	□ Lipo Laser treatment (40-50 minutes)
___ / ___ / ___	□ Whole Body Vibration (10 minutes)
	□ Sauna (20 minutes)
	□ Verify next scheduled visit
VISIT 8	□ Apply Heat to areas being treated by Lipo Laser
___ / ___ / ___	□ Lipo Laser treatment (40-50 minutes)
	□ Whole Body Vibration (10 minutes)
	□ Sauna (20 minutes)
	□ Verify next scheduled visit
VISIT 9	□ Final Evaluation
	□ Apply Heat to areas being treated by Lipo Laser
___ / ___ / ___	□ Lipo Laser treatment (40-50 minutes)
	□ Whole Body Vibration (10 minutes)
	□ Sauna (20 minutes)
	□ Verify next scheduled visit
	□ Take “After” Picture and record after measurements
	□ Measure for inch loss
	□ Offer Maintenance program
	□ Follow up Symptom Survey at ClubReduce.com®
	□ Evaluation to review progress and to determine patients next steps

*Staff must initial everything they complete.

THE 3-WEEK LIPO LASER PROGRAM EVALUATIONS

Patient Name: _____ Age: _____ Height:_____ Anticipated Start Date of Program: _____

Visit #		**Visit #**		**Visit #**		**Visit #**	
Date	___ / ___ / ___	Date	___ / ___ / ___	Date	___ / ___ / ___	Date	___ / ___ / ___
Weight		Weight		Weight		Weight	
Digestion		Digestion		Digestion		Digestion	
Elimination		Elimination		Elimination		Elimination	
Sleeping Habits		Sleeping Habits		Sleeping Habits		Sleeping Habits	
Energy Level		Energy Level		Energy Level		Energy Level	
Lipo Laser:		Lipo Laser:		Lipo Laser:		Lipo Laser:	
Whole Body Vibration:		Whole Body Vibration:		Whole Body Vibration:		Whole Body Vibration:	
Sauna:		Sauna:		Sauna:		Sauna:	
SMT:		SMT:		SMT:		SMT:	

THE 3-WEEK LIPO LASER PROGRAM

PRODUCTS

Patient Name: _____ Date: ___ / ___ / ___

✓	# of Units	Products Included in Program:	Price:
	1	Appetite Appeaser	$24.00
	1	Cellulite Cleanse	$24.00
	1	Detoxification Kit (Includes Body Purifier, Fiber Blend and Intestinal Cleanser)	$69.00
	2	Mixture Bottles (For the Lemonade Detox)	$8.00
	1	Multivitamin / Multimineral	$32.00
	1	Anti-Cellulite Lotion	$25.00
	1	Exercise Gel	$29.00
	2	Nutritional Shake	$100.00
	1	Vitamin D	$15.00
			Total Price $326.00

I have checked off (✓) the products above and I verify that all of these products are included in this packet:

By signing this, I acknowledge that I have been given all of the products that I need for the duration of this program. If I choose to take more supplements on some days, I know that I will have to purchase more if I run out.

_____ ___ / ___ / ___
Signed Date
(Patient Signature)

_____ ___ / ___ / ___
Signed Date
(Employee Signature)

THE 3-WEEK LIPO LASER PROGRAM CONTRACT

✓	Products and Services Received	Per Unit	Price
1	**3-Week Lipo Laser Supplements and Products**	$326.00	$326.00
9	**Lipo Laser Spot Reducing Treatments**	$333.00	$2,997.00
9	**Whole Body Vibration Treatments**	$30.00	$270.00
9	**Sauna treatments** for detoxification	$30.00	$270.00
3	**Weekly Evaluations** to review progress	$50.00	$150.00
3	**Self Mastery Technology (SMT)**	$30.00	$90.00
1	**Follow up Evaluation** at the completion of this program	$75.00	$75.00
	24 Hours a day phone access to the Doctor and Staff		Priceless!
	Total Price for Everything		$4,178.00
	Your Price		_____

Your signature below indicates that you understand the following: All sales are final. You are solely responsible for any treatment rendered in this office. All services rendered to you are charged directly to you, and you are personally responsible for payment. This office does not accept insurance of any kind. (Please advise us immediately if you are a Medicare patient, as we do not treat Medicare patients for services covered by Medicare.)

If you purchase this entire package, a discount may be given. You understanding that if the entire program isn't completed, the discount becomes void and the items and services rendered will be charged at the rates listed above.

If you move from the area before your program is completed, we will issue a store credit up to 3 months after the purchase date. The store credit will be good for any services not yet rendered that were scheduled to be performed after the date of your move. The amount of the store credit for those services will be given at the rate that was originally charged. If a discount was given, the credit will reflect that. All product sales are final and no refunds will be given, as you can and should continue to take the products.

When you are scheduled for a service or appointment, a room and employee are reserved for you. If you don't show up, the employee member and room assigned to you are not utilized, and resources are wasted. Therefore, if we do not have a 48-hour notice of cancellation for an appointment, you may still be charged for that service as if you had been here.

You authorize the staff to perform any necessary services needed during treatment.

You understand the above information and guarantee that this form was completed correctly to the best of your knowledge and understand it is your responsibility to inform this office of any changes to the information you have provided.

Your signature indicates that you understand these policies and that you will comply with the above requirements.

_____ ___ / ___ / ___
Patient Name Printed Date

_____ ___ / ___ / ___
Patient Signature Date

_____ ___ / ___ / ___
Employee Signature Date

THE 3-WEEK LIPO LASER PROGRAM

DISCLAIMER

Lipo Laser is a new and innovative technology that has been designed for spot fat reduction and body contouring. Since its launch in the European and Asian markets in 2006 it has been generating significant interest and has shown to be a very effective treatment.

Lipo Laser is one of the tools that we can use to help you reach your goals and the real advantage of this technology lies in the fact that we can specifically target a trouble area. Once the fats have been released from the cell they can be used by the body as a fuel source. It is therefore critical that the dietary and lifestyle changes are made to help support the goals of treatment.

A reduced calorie diet and an exercise program that will help to burn approximately 350 – 500 calories post treatment are ideal. Individual results may vary and it is the responsibility of the patient to ensure they are doing the appropriate home care to ensure maximum results. Patients should be consuming a caloric intake equivalent to their target weight (lbs) multiplied by 10. For example a 220lb male who wants to reach 200 lbs should be consuming a daily intake of 2000 calories. In some cases additional support may be required for lymphatic drainage to help stimulate the body to clear the fats that are released from the cell. Most patients experience a ½ inch reduction with each treatment and multiple inches can be lost with a series of treatments.

Patient Agreement

I, _____, in signing this agreement understand that I am beginning a series of treatments to help reach my goals of body contouring and spot fat reduction. I understand that individual results may vary and that I must commit to changing the dietary and lifestyle factors necessary to achieve optimal results. I understand that the first step to a positive change is creating awareness about the steps necessary to reach these goals, and will work diligently to ensure success. I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I realize there may be pre-existing medical conditions that can preclude me from seeing optimal results. By signing this agreement I release the spa/clinic, manufacturer and distributors from any liability regarding this treatment and do so understanding that results can vary from one individual to the next. I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form. If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever, concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Patient: _____ Date: ___ / ___ / ___

Employee: _____ Date: ___ / ___ / ___

Patient Consent for Treatment

Welcome and Congratulations!

This is an important decision towards improving your wellness and overall lifestyle!
We share the mutual desire of you reaching all of your wellness goals involving the BCS Lipo Laser. 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 Lipo Laser treatment protocol.

Ensure Your Best Results

- Drink plenty of water after every treatment
- Incorporate Whole Body Vibration (WBV) post treatment for 10 minutes
- Ensure you undertake physical activity 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

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:

- 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;
- Must notify the clinician if my medical history changes prior to subsequent treatments;
- Consent to photographs of the treatment area;

I _____ consent to, and authorize _____ to perform the
(Print Clinician's Name)

Lipo Laser treatment for _____.
(Print Treatment Area)

_____
Signature Patient

_____ ___ / ___ / ___
(Printed name of Signatory) 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.

Checklist for Explaining Program

DATE:_____ PERSON EXPLAINING PROGRAM:_____

PATIENT:_____PROGRAM:_____

INVENTORY

_____Complete product Inventory with patient
_____Have patient sign product inventory
_____Have Wellness Coach sign product inventory
_____ Emphasize to patient that the program includes ALL SUPPLEMENTS needed for the program. If the patient runs out because they use more than allotted or share them, they can purchase more from our clinic or online. They will NOT be given any more for free.

REFERRAL PROGRAM

_____Review Referral Program. This is a great way to get free product!!!
_____Give them Patient Referral Program Instructions (2 pages)
_____Give them 3 Patient Referral Cards

ONLINE REVIEW PROGRAM

_____Explain our on-line review program
_____Give them instruction form for online reviews

WEEKLY TREATMENTS/PROCEDURES

_____Give patient "Services" Brochure
_____Explain each weekly visit procedure (They need to come to Wellness Coach before treatments)
_____Let them know what they need to wear
_____Let them know they MUST bring their food journal each week (NO EXCEPTIONS!)

NUTRITION PROGRAM

_____Review Food List
_____Calculate how much water they must drink each day
_____Review Structuring Your Diet
_____Review Detox
_____Review Healing Crisis
_____Review How to Take Your Supplements
_____Review Daily Food Log (Food/Supplement Instructions and How to record food eaten)

CLUB REDUCE WEBSITE AND SOCIAL MEDIA

_____Give tour of Club Reduce membership site
_____Invite them to follow us on Facebook, Twitter, Pinterest, and our Blog
_____Invite them to the next class (cooking class, yoga class, etc.)
_____Invite them to the Monday Support Group

_____

EMPLOYEE SIGNATURE

Congratulations on Your Decision to Take Control of Your Health and Your Weight!

We have helped thousands of patients discover true health!

Typically, patients come to us to lose weight. What they don't realize is that although they will lose their weight, the most exciting part of the journey is the renewed energy and zest for life they discover.

We have found that most patients have spent years of unhealthy living in order to gain their weight and arrive at the condition they are in when they come to us for help.

Just as it took years of unhealthy living to gain your weight, it will take time to get healthy and arrive at your goal weight. But don't worry, you'll see some quick progress too!

Our goal is to be your lifetime partner in your quest to lose your weight, then maintain your weight and finally remain healthy!

This is a process that is a lot of work…yet EXTREMELY rewarding.

Even though you have signed up for a program with a beginning date and an ending date, that is only for the first phase.

The first phase typically is to get you started on your weight loss journey. During this first phase, there are things you can expect from us and there are things we expect from you.

- Here are the 5 Things You Can Expect from Us:
    1. Detailed program guidelines to help you lose your weight
    2. Supplementation to help with dieter's nervousness and overall success
    3. Weekly visits to make sure you are on track
    4. Weekly phone calls in between visits to make sure you are on track
    5. Access to everyone on our staff that can assist you!

- Here are the 5 Things We Expect From You:
    1. Stick with all the program guidelines
    2. Record everything daily in your binder
    3. Show up for all your appointments
    4. Bring your binder with you to each visit
    5. Refer at least two patients to us every six months. (We have a message to spread!)

This is an exciting process. You will have ups and you may have downs. But we are here for you!

We are now your health partners for life, and we take this role very seriously!

Please communicate all of your concerns and needs to us. Our goal is to help you reach your goals! Welcome to our Club Reduce Family!

_____	_____	_____	_____
Patient Signature	Date	Staff Signature	Date

Preferred Patient Referral Program

Each week in staff meeting we discuss our patients and how we can better serve them.

While all of our patients are important to us, some of our patients just make our work extra enjoyable!

You are one of those patients that we have singled out as "making our work extra enjoyable!"

We all look forward to your visits in our office, and quite frankly, we wish we had more patients JUST LIKE YOU!

Because of that, we have a "Preferred Patient Referral Program" implemented in our office called…

"We Want More Patients Like You!"

Here are some questions you might be asking:

What is Our Goal? To obtain more awesome patients that make our work enjoyable, like you do!

Why Would You Want to Participate? For every person that you refer that either attends one of our seminars or comes in for an evaluation, you'll receive one of the following:

- ☐ $25.00 Coupon for Products or Services in our Office
  Or
- ☐ Free Chocolate Nutritional Shake (Yes, you could also choose Strawberry, Orange or Vanilla)
  Or
- ☐ Free Body Wrap (Lose ½ Dress Size in one Wrap!)

Will This Be a Hassle for You to Participate in? No! Simply fill in the information on the back of this sheet with the names of the people that you think might be interested in some of our services. (You might not even be aware of all of the services we have available. Please see the back so you can see them all!)

Will We Be Bothering People You Refer? No! They will receive something in the mail…that's all! All we need from you is the name and mailing address for the people you'd like to refer. (If you don't have their address, we can search for it online.) We won't call, email or bother your friends. We'll simply send them something interesting in the mail. If they are interested, they'll respond; if they aren't, we won't be contacting them by any other means!

How Many People Can You Refer? We'd love all the referrals you'd like to give! We've had some patients that have referred so many that they've had lots and lots of credit in our office for products and services. That makes us happy, you happy and your referred friends happy!

How Will You Know If Your Referrals Come in? We make a point to find out where every patient comes from, so we can thank you and get your referral bonuses to you!

Your Name: _____

At Lighthouse Health, we have many programs available such as:

Breakthrough Weight Loss	Diabetes/Blood Sugar Issues	Skin Care Programs
Kids Weight Loss	Candida	Body Wraps
Teen Weight Loss	Fibromyalgia	Saunas
Family Weight Loss	Pain Relief	Detoxification Programs
Personal Training	Hormone Balancing	Maintenance

We would love to send out some literature on some of these programs to your friends, family, co-workers, or any other acquaintance you can think of who might benefit from this information. Please list people you know you might have an interest in any of this information. Please use an additional sheet if needed.

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____

Name _____

Address _____

City, State, Zip Code _____

Information to Send (Optional) _____