Atlanta Colonic & Massage Spa

Complete for FlowPresso® Session

Why have you chosen to have a FlowPresso® session?

Doctor suggestion or prescription: ☐ Right to Self-Treat: ☐ Other: _____

Have you previously experienced a FlowPresso® session (within last 5 years)? Yes ☐ **No** ☐

If so, where and when? _____

Are you experiencing or have you have been diagnosed with any the following?

NOTE: A referral from your doctor will be required before receiving FlowPresso® session.

Contraindications:

- ☐ Asthma/Respiratory Breathing issues
- ☐ Low/High Blood Pressure
- ☐ Blood Clots
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Hemorrhaging
- ☐ Skin Infections
- ☐ Internal Infections
- ☐ Open Wounds
- ☐ Aneurysm (any type)
- ☐ Cancer (any type)
- ☐ Heart Problems
- ☐ Congested Heart Failure
- ☐ Claustrophobia/Fear
- ☐ Pacemaker
- ☐ Pregnant (or potentially pregnant) ?

Are you currently taking or have recently taken any medications which may cause health issues related to having external compression applied to your body? (bleeding, bruising, etc.) **Yes**☐ **No**☐

If YES, please explain: _____

_____

Have you had any surgeries in the last 12 months? **Yes**☐ **No**☐

If YES, please explain procedures & dates: _____

_____

Have you ever been diagnosed with an infectious disease? **Yes**☐ **No**☐

(HIV/AIDS, Hepatitis A, B, or C, etc.)

If YES, please explain: _____

Any other potential health or medical conditions not previously disclosed? **Yes**☐ **No**☐

If YES, please explain: _____

What is your primary health goal or concern at this time?

_____

_____

FlowPresso®

Acknowledgement & Informed Consent

I, the undersigned, confirm I have discussed all contraindications on this form as they may apply to me with the therapist, related to **FlowPresso®** session. I acknowledge Atlanta Colonic & Massage (ACM) Spa personnel, including **FlowPresso®** therapists, are not physicians and cannot diagnose, treat, prescribe or perform any invasive procedures. I am aware that possible adverse events may occur as a result use of this session, based on my current personal health, wellness and medical condition.

As such, I am fully responsible for managing and monitoring my own session. If during a session I experience discomfort, pain or feel unwell, I am responsible for immediately stopping the session and notifying ACM staff.

I, the undersigned, agree that **FlowPresso®** is not a proven method, cure, or session of any medical condition, disease or illness, nor has it been portrayed to me as such by ACM.

I fully understand **FlowPresso®** is not a substitute for any medical advice or treatment. I acknowledge Atlanta Colonic and Massage does not claim to treat, cure or prevent any condition, illness or disease.

All **FlowPresso®** session is provided in good faith and with full explanation of the session program and possible consequences. As with any practice involving the body, a particular action may have varying degrees of success and duration or quantity of session required.

The **FlowPresso®** equipment utilized in this facility is not a FDA Registered device. I understand I will be in full control of my session at all times. The facility I have chosen to visit operates under existing state & federal laws at the time I sign this waiver of consent and that that those laws may change. Neither I, nor my family, nor my representative(s) will hold the equipment manufacturer, facility or their employees responsible for my personal choice to receive **FlowPresso®** session, nor hold them liable for any changes or variations of the law after my dated signature below.

By my signature below, I attest and affirm that I have been provided with an opportunity to discuss all potential concerns, issues and contraindications/adverse conditions, and any questions have been fully answered to my satisfaction. I certify that none of contraindications/adverse conditions applies to me. I certify and affirm that I have listed all my known health and medical conditions and answered all questions fully and honestly. I agree to keep the ACM staff updated as to any changes in my medical profile, and understand there shall be no liability to ACM or on its staff should I fail to do so.

I have also read, understand and agree to Atlanta Colonic & Massage's Spa appointment cancellation/rescheduling policy.

Client Printed Name: _____
Last *First* *MI*

Client Signature: _____ _____
(for clients age of 18 or older) *Date*

Parent/Legal Guardian Name/Signature: _____ _____
(for clients under age of 18, signature of parent/legal guardian required) *Date*