Appointment Preparation Instructions

Electro-Lymphatic Drainage Therapy is noninvasive, painless, and very calming and relaxing. It is similar to having a light touch massage. A certified lymphatic therapist uses an instrument with two small hand held wands to slowly and lightly massage the body in a specific direction that correlates to the body's lymphatic flow. The procedure is done on a massage table for which you will need to disrobe in the same way you would when getting a massage. Draping is used to cover clients to protect their modesty. Underwear is to remain on.

A combination of vibration, light and electrical waves help to stimulate the flow of the lymph by breaking up congested lymph fluid to release it from the body. Think of a jar of water with gelatin that is very thick and gelatinous, which is similar to congested lymph. If you shake the jar the liquid becomes more fluid. The vibration of the instrument works in the same way to break up the lymphatic congestion.

Before Treatment:

- Be hydrated upon arrival to help jump start your treatment.
- Please be aware that treatment may increase absorption of medications, therefore less may be needed.
- ALL jewelry must be removed during treatment.
- DO NOT apply oils, lotions, or deodorant to the skin (make-up is acceptable).
- Women should wear natural fabric for panties (cotton); Men should wear cotton loose boxers.

After Treatment:

- Nursing mothers will need to pump 2-3 times and discard milk to be clear of toxins.
- Over the next 48 waking hours, drink at least 8 oz of water every 2 hours. If available, add lemon juice.

These statements have not been evaluated by the FDA. This product is not intended to diagnose, treat, cure or prevent disease. Under US Law only a medical doctor may "treat" illness and disease with a medical origin such as cancer. This law is to protect you from the possibility that, while you are receiving therapy, an illness which may need orthodox attention could be getting worse.

By signing I agree to follow these prep instructions, understand the above statements, and acknowledge that failure to follow these instructions properly may result in being unable to receive lymphatic therapy and a consequent cancellation fee.

Signature _____

Date_____

Electro Lymphatic Therapy - Thermography Advantage

I, _____ hereby acknowledge that I am the client of Thermography Advantage and hereby give my permission to participate in Lymphatic Therapy and any other services offered by Thermography Advantage.

As an integral part of such permission, I recognize that Lymphatic Therapy is a naturalist, experimental, alternative procedure, the purpose of which is not in diagnosing, healing, or curing, but to help promote good health and well-being.

Therefore, I herby agree to hold Thermography Advantage harmless from and against any and all claims, demands, liabilities, and actions, causes of actions, damages and/or expenses of any nature or kind without limitation arising from my direct or indirect participation in any of the aforementioned therapies.

I hereby acknowledge that I assume the risk if any and I will assume all damages if ever needed. I waive any cause of action that I might have at any time against Thermography Advantage or that I might thereafter accrue as a result of any therapeutic services.

I have had an opportunity to review this waiver and ask any questions concerning its meaning or intent. I verify that I have read this entire document, have had reasonable opportunity to ask questions concerning its application, understand its contents, and acknowledge that the various information provided throughout this document is accurate and complete.

I further acknowledge and verify that I have full legal authority to execute this document and that there are not requirements, conditions or obligations, legal or otherwise, which would require the consent or assent of any other person or entity.

Signed this the _____ day of _____, 20____

Signature_____

Printed Name_____

Patient Name: _____ DOB: _____

THIS PROCEDURE SHOULD NOT BE PERFORMED IF ANY OF THESE APPLY
PLEASE CIRCLE YES IF ANY APPLY, AND NO IF THEY DO NOT APPLY

YES OR NO • ARE YOU ON A BLOOD THINNER

YES OR NO • ARE YOU PREGNANT OR DO YOU THINK YOU COULD BE PREGNANT

YES OR NO • DO YOU HAVE OR EVER HAD THROMBOSIS OR BLOOD CLOTS

YES OR NO • DO YOU HAVE OPEN WOUNDS OR SORES

YES OR NO • HAVE YOU HAD AN ORGAN TRANSPLANT

YES OR NO • DO YOU HAVE CELLULITIS (NOT CELLULITE)

YES OR NO • HAVE YOU EVER HAD SIEZURES

YES OR NO • DO YOU HAVE A KIDNEY AILMENT

YES OR NO • HAVE YOU EVER HAD PLASTIC SURGERY (especially LIPO, Botox, or Fillers)

YES OR NO • DO YOU HAVE ANY TYPE OF MEDICAL DEVICE FOR THE HEART (e.g. pacemaker)

Notice of Privacy Practices

The Department of Health and Human Services has established a 'Privacy Rule' to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their client's consent for uses and disclosers of health information about the client to carry out treatment, payment or health care operations. As our client we want you to know that we respect the privacy of your personal medical records and that we will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not clients), and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse in writing to consent to the use or disclosure of your personal health information.

I, _____, have received and reviewed a copy of Thermography Advantage's Notice of Privacy Practices.

Signature of the client or the client's guardian:_____Date: _____

Client Contact Consent

By signing below you are giving permission to contact you by any telephone number or e-mail address associated with your account for the purpose of appointment reminders, in regard to services provided, or to collect monies owed. This permission extends to Thermography Advantage as well as any agents employed/associated with us.

Signature _____ Date _____

NAME_____DATE_____

ADDRESS_____CITY/STATE_____

PHONE: HM_____WK_____CELL_____

EMAIL ADDRESS_____DATE OF BIRTH_____

PHYSICAN REFERRED BY_____

WHAT DO YOU HOPE TO GAIN FROM LYMPHATIC TREATMENTS OR WHAT SYMPTOMS DO YOU WANT TO RELIEVE?

_____

_____

_____

_____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (CHECK ALL THAT APPLY)

☐EMOTION CHANGES	☐ALLERGIES	☐TMJ SYNDROME
☐LYME DISEASE	☐PREGNANCY (CURRENTLY)	☐SPORTS INJURY
☐FLU (CURRENTLY)	☐ACUTE PAIN	☐ SKIN DISORDERS
☐ULCERATED COLON	☐KIDNEY AILMENT	☐MIGRAINE
☐NECK/SPINE INJURY	☐VARICOSE VEINS	☐CHEST PAIN
☐CANCER	☐P.M.S. SYNDROME	☐DIABETES
☐FEVER (CURRENTLY)	☐CHRONIC PAIN	☐FIBROMYALGIA
☐ELEVATED CHOLESTEROL	☐PHLEBITIS	☐GRIEF PROCESS
☐INFECTIOUS CONDITIONS	☐HEART AILMENT	☐ACCIDENTAL INJURY
☐OSTEOPOROSIS	☐HIGH BLOOD PRESSURE	

☐ANY OTHER CONDITION NOT LISTED? _____

PLEASE CIRCLE ANY OF THESE PRODUCTS THAT YOU USE THAT ARE NOT NATURAL:

DEODERANT ☐ SUNBLOCK ☐ SPRAY TAN ☐ BODY LOTIONS/OILS ☐ HAIR PRODUCTS ☐

PLEASE STATE ANY RECENT OR PAST INJURIES OR MEDICAL TREATMENTS:

_____

_____

_____

PLEASE STATE ALL SURGERIES: (NEEDED FOR CORRECT ROUTING OF DRAINAGE)

_____

_____

_____

_____

ARE YOU CURRENTLY UNDER THE CARE OF A HEALTH PROFESSIONAL: _____YES _____NO

HEALTHCARE PROVIDERS NAME_____ NUMBER_____

EMERGENCY CONTACT _____

RELATIONSHIP_____NUMBER_____