DATE: _____

Your information will not be shaired with any third party without your permission. We may attempt to contact you at any of the numbers/addresses you provide. While we always try to be as discreet as possible, please do not provide numbers at which you do not wish to be contacted or any communication.

NAME: _____ DATE OF BIRTH: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (mobile) _____ other _____

Email: _____

How did you hear about Mélange? ☐ FRIEND _____

☐ MY DOCTOR/NURSE _____

☐ GOOGLE/WEB SEARCH ☐ FACEBOOK/INSTAGRAM ☐ CHAMBER OF COMMERCE ☐ MIRADRY WEBSITE

☐ CHECK BOX IF YOU WOULD LIKE TO BE ADDED TO OUR EMAIL LIST FOR THE LATEST INFORMATION & SPECIALS BEING OFFERED

Thank you for choosing Mélange. In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessaray to help you fully understand it.

PLEASE INITIAL NEXT TO EACH PARAGRAPH AND SIGN ONLY AFTER CAREFUL REVIEW.

Disclosure of Medical History

_____ I agree that I will disclose a full and accurate personal medical history, including any and all information regarding medical conditions and my use of medications, drugs, herbs, vitamins, or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of complications.

Confidentiality

_____ I understand that no information regarding services performed shall be released without my express consent except as follows: I understand that, in addition to Mélange personnel, the Medical Director and consulting physicians shall have full access to my treatment records. I understand that appropriate medical review may be conducted to further the safety and efficacy of Mélange services. I understand that photographs may be taken to document treatment results, but they will not be relwased or used otherwise without my specific written consent. Mélange will maintain file copies of all records for a minimum of 3 years.

Continued Consent

_____ I understand that Mélange services may require follow up treatments to achieve optimal results, and this consent shall apply to all services rendered to me by Mélange, including ongoing or intermittent treatments.

_____ I further understand that any additional treatment that may be necessary is my personal financial responsibility and I am responsible for any additional costs.

_____ I certify that I am competent adult of at least 18 years of age.

_____ My signature attests to the fact that I have fully read this entire consent form and that I have had any questions or concerns answered to my satisfaction. I understand and agree to the information contained herein.

_____ _____

Patient Signature Date

_____ _____

Witness Date