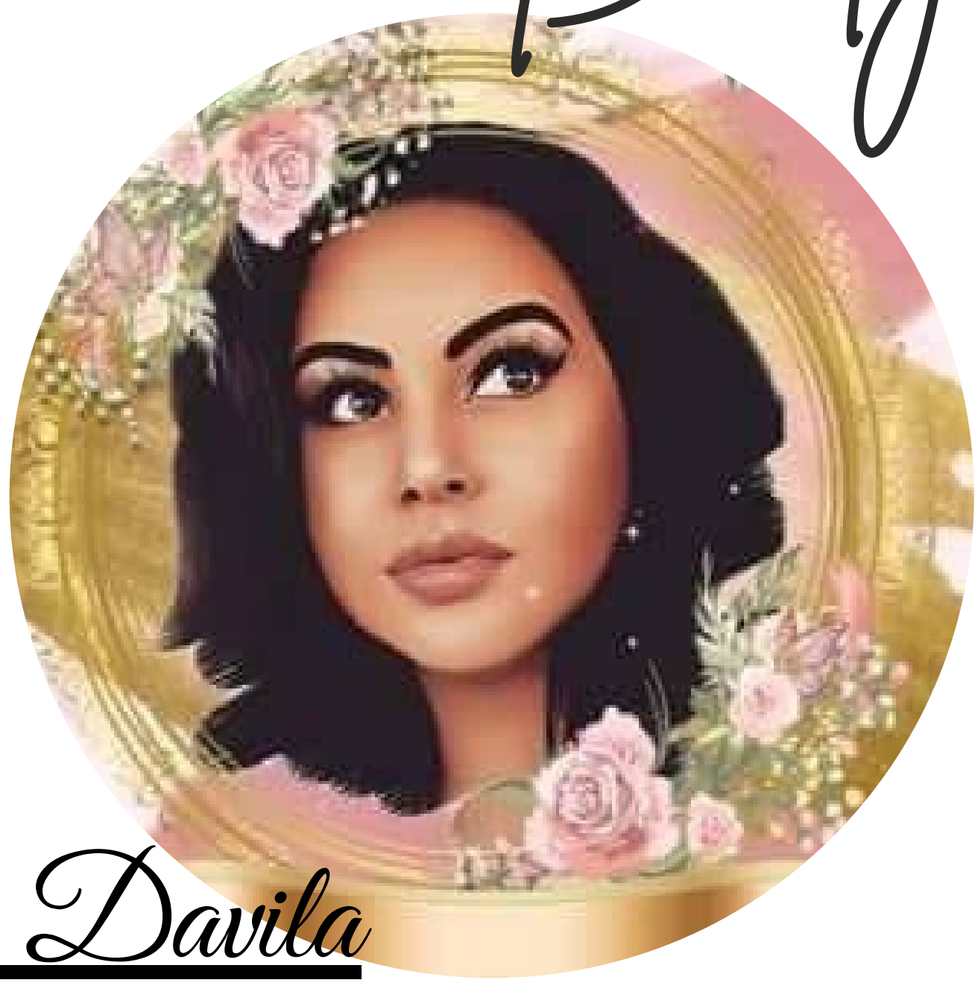
# Body Sculpting



Touch of Beauty & Relaxation 4ever

## Stefanie Davila

LICENSED COSMETOLOGIST & MASSAGE THERAPIST

## Post Surgery Care Plan Package

Appointments Available

405-404-6046

Traveling Post Surgery Treatments

Stefanie Davila

LICENSED COSMETOLOGIST & MASSAGE THERAPIST

Touch of Beauty & Relaxation 4ever INC

Body Sculpting

# POST SURGERY LYMPHATIC DRAINAGE

## Medical Massage

Post Natal Cesarean
B.B.L
Tummy Tuck
Liposuction
Breast Augmentation
Arm Lift
Thigh Lift


## Manuel Lymphatic Drainage Post Surgery Benefits

- Speeds up Recovery
- Bruising Reduction
- Swelling & Edema Reduction
- Pain Reduction
- Improves Mobility & Comfort
- Scar Tissue Prevention
- Infection Prevention
- Enhances Circulation
- Improves Lymph Flow
- Prevent and Decrease Severity of Fibrosis
- Better Sleep

# 30 MINUTES- $65

# Stefanie Davila

## LICENSED COSMETOLOGIST & MASSAGE THERAPIST

# Body Sculpting

Touch of Beauty & Relaxation 4ever INC

## Cavitation Treatment

Ultrasonic cavitation is best for reducing cellulite and adipose fat.
This improves body shape and contour and reduces circumference.
It is vital to maintain a low-calorie balanced diet and to perform physical exercise after completing the cavitation procedure.

What is Ultrasonic Cavitation & Radio Frequency Facial Treatment: Ultrasonic rejuvenates and helps repair your skin and stimulates its natural healing. This high-tech facial uses a specialized ultrasound machine that emits high-frequency wave

Utrasonic Facial

Body Contour

STARTING AT
**$85.00**

Body Sculpting

# WOOD THERAPY

## Body Contour & Sculpting

Touch of Beauty & Relaxation 4ever INC

*Stefanoe Davila*

**Medical Massage Therapist**

## Wood Therapy Treatment

- **Body Contour & Sculpting helps to boost your metabolism.**
- **Employs purposely shaped wood pieces to sculpt the body in desired areas, allowing the therapist to move and drain accumulated adipose tissue**
- **This release of toxins jumpstarts metabolism to burn fat**

## Benefits of Wood Therapy

- **To relax mind and body.**
- **Loosen tight, restricted muscles.**
- **Stimulate lymphatic drainage.**
- **Eliminate toxins.**
- **Speed metabolism.**
- **Breakdown cellulite.**
- **Burn fat.**
- **Tone and tighten**

**30 Minutes: $85**

**60 Minutes: $175**

*Body Sculpting*

# PRE & POST TREATMENT ADVICE

Demo consultations are available prior to Surgical procedure to help go over the care plan package with pre and post treatment advice to help ensure a better result for future treatment and quicker recovery for overall results.

$45- Demo Consultation is a 30 Minute Session
Includes: 15 Minute Lymphatic drainage massage with client & therapist questionnaire and care plan consultation.
Pre booking for 6 week program will be available with sessions 2-3 times a week minimum
6 week program will alternate between massage, cavitation and wood therapy treatments

Drinking lots of water daily and is required the day of and before each treatment.

Avoid heavy meals the day before & do not eat 2 hours prior to your treatment.

Maintain a healthy diet with adding extra fiber, fruit, protein and healthy carbs.

Avoid heavy dairy products such as milk, cheese or anything that could slow down or clog the digestive tract that would cause constipation

Avoid caffeine, alcohol and carbonated drinks throughout the 6 week care plan to the best of your ability.

Not required but recommended- Arnica tea has active ingredients to help as a mild anti-inflammatory, analgesic, and antiseptic actions and detoxifying benefits.

Consult with your physician for recommended vitamins for daily balance for nutrition, Carries anti-inflammatory properties and may promote wound healing, their antioxidants help the body recover and manage cell damage.

Engage in light exercises daily with walking or gentle movements
20 Minutes from 1 -2 times a day. Try not to sit for long periods of at a time.
No strenuous cardio, stretching or heavy lifting unless instructed by physician

Massage the targeted areas instructed by therapists daily for 10-15 Minutes with light strokes and upward motions for stimulation and blood circulation to help break up stagnation and promote oxygen.

Proper care and use of needed compression of designated post surgery attired is recommended. For overall results and reduced swelling. Alternating wraps, proper foam placement and sizing is vital for overall recovery and lasting results.

Avoid sauna, spa, hot tubs, hot showers until instructed by physician

Avoid Cyrotherapy after surgery unless instructed by physician

Bowel movements play an important role in removing the fat tissue adipose with the lymphatic system by removing waste and 2-3 times a day is ideal. Consult your physician if you are constipated 3 or more days or signs of diarrhea lasting more then 3 days.

Get lots of rest, but try not to stay bed ridden or laying down to long for long periods of time with ample movement in between.

Following the 6 week care plan package regimen is a vital importance to overall health and the recovery process for better results and recovery.
Not following the guidelines can result in elimination for future treatments.
**Pre purchased session are non refundable.**

I have read and fully understand the above Pre & Post Care Plan and agree to be bound by it's terms. I agree to follow the guidelines of the care plan package to the best of my ability and understand failure can result in elimination of future appointments and non refundable sessions pre-paid prior.

Client Name (printed) :

Client Name (signature) :

Date:

*Body Sculpting*

# Care Plan Package Schedule

Following the 6 week care plan package schedule regimen is a vital importance to overall health and the recovery process for better results and recovery.

Not following the guidelines can result in elimination for future treatments.

**Pre purchased session are non refundable.**

## Week 1- 2-3 Times

**Each Session may alternate or combine Massage, Cavitation or Wood Therapy. Each Clients Results may vary and not all modalities are required or neccesary for each session**

Manual Lymphatic Drainage Massage

## Week 2-3- 2-3 Times

**Each Session may alternate or combine Massage, Cavitation or Wood Therapy. Each Clients Results may vary and not all modalities are required or neccesary for each session**

Manual Lymphatic Drainage Massage
&
Cavitation Treatment

## Week 3-4- 1-2 Times

**Each Session may alternate or combine Massage, Cavitation or Wood Therapy. Each Clients Results may vary and not all modalities are required or neccesary for each session**

Manual Lymphatic Drainage Massage
&
Wood Therapy

## Week 4-6 1-2 Times

**Each Session may alternate or combine Massage, Cavitation or Wood Therapy. Each Clients Results may vary and not all modalities are required or neccesary for each session**

Manual Lymphatic Drainage Massage
Cavitation Treatment
&
Wood Therapy

I have read and fully understand the above Post Care Plan Schedule and agree to be bound by it's terms.
I agree to follow the guidelines of the care plan schedule to the best of my ability and understand failure can result in elimination of future appointments and non refundable sessions pre-paid prior.

Client Name (printed) :

Client Name (signature) :

Date:

*Body Sculpting*

# Care Plan Package Bundles

Following the 6 week care plan package schedule regimen is a vital importance to overall health and the recovery process for better results and recovery.

Not following the guidelines can result in elimination for future treatments.

**Pre purchased session are non refundable.**

## Manual Lymphatic Drainage Massage

**3 Sessions**
30 Minute sessions
Lymphatic Drainage Massage

**$185**
*Save $10*

**6 Sessions**
30 Minute sessions
Lymphatic Drainage Massage

**$365**
*Save $25*

**10 Sessions**
30 Minute sessions
Lymphatic Drainage Massage

**$550**
*Save $100*

## Cavitation Treatment

**3 Sessions**
30 Minute sessions
Cavitation Treatment

**$245**
*Save $10*

**6 Sessions**
30 Minute sessions
Cavitation Treatment

**$485**
*Save $25*

**10 Sessions**
30 Minute sessions
Cavitation Treatment

**$750**
*Save $100*

## Wood Therapy

**3 Sessions**
30 Minute sessions
Wood Therapy Treatment

**$245**
*Save $10*

**6 Sessions**
30 Minute sessions
Wood Therapy Treatment

**$485**
*Save $25*

**10 Sessions**
30 Minute sessions
Wood Therapy Treatment

**$750**
*Save $100*

## Manual Lymphatic Drainage Massage, Cavitation & Wood Therapy Treatment

**3 Sessions**
60 Minute sessions
Manual Lymphatic Drainage Massage, Cavitation & Wood Therapy Treatment

**$690**
*Save $15*

**6 Sessions**
60 Minute sessions
Manual Lymphatic Drainage Massage, Cavitation & Wood Therapy Treatment

**$1,375**
*Save $35*

**10 Sessions**
60 Minute sessions
Manual Lymphatic Drainage Massage, Cavitation & Wood Therapy Treatment

**$2,250**
*Save $100*

I have read and fully understand I am responsible and agree to pay for total amount of the sessions required for the 6 week care plan package purchased. In results of in completion of treatment sessions, or termination of treatments; pre-paid sessions purchased with any balance left over will be lost and are non refundable.

Client Name (printed) :

Client Name (signature) :

Date:

*Body Sculpting*

# CONSULTATION FORM

Touch of Beauty & Relaxation 4ever INC

## PERSONAL INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ Female Male NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

How did you hear about us? _____

**Would you like to be added to our email list for news and exclusive offers? Y N**

## MEDICAL HISTORY

Do you have or have you had any of the following conditions? *If yes, please select them*:

- Autoimmune disease
- Gallbladder removed
- Skin sensitivity
- Back/Neck pain
- High blood pressure
- Thrombosis/Phlebitis
- Cancer / Chemo
- History of gallstones
- Thyroid condition
- Cardiovascular condition
- Infections
- Tumors
- Diabetes
- Liver condition
- Metal bone pins/plates
- Epilepsy
- Skin diseases
- Phlebitis, blood clots

Any chronic medical conditions? No if Yes: _____

Do you have hearing aids, pacemaker or hormone pellets (where) or metal/medical devices implanted? No Yes

Do you have or have had cancer in the last 12 months? No Yes

If yes, are you currently on chemotherapy? No Yes

History of Colon problems including protruding/distended belly? No Yes

Any known allergies? No Yes

List any medications you take regularly: _____

Any recent surgery, including plastic surgery? No Yes, explain: _____

_____

_____

# BODY SCULPTING CONSULTATION FORM



♀ When is your next menstrual cycle due to begin? _____

*(Do not schedule Non-Surgical Lipo, Cavitation, or RF Skin Tightening treatments during your cycle. Your cycle will become heavy.)*

Are you pregnant or trying to become pregnant? No ☐ Yes ☐

Are you breastfeeding? No ☐ Yes ☐

What is your primary area(s) of concern? _____

Do you want to loose body fat? No Yes

If yes, from what area(s)? _____

Do you want cellulite reduction? No Yes

If yes, from what area(s)? _____

Do you want to tighten skin on your body? No Yes

If yes, what area(s)? _____

Do you follow a current diet plan? No Yes

If yes, please explain? _____

Are you having regular exercise? No Yes

If yes, how often and what type? _____

Do you drink alcohol? No Yes

If yes: Once a month or less ( ) 2-4 times a month ( ) 2-3 times a week ( ) 4+ times a week

Do you drink water daily? No Yes

If yes, how much? ( ) 1-2 bottles ( ) 3-4 bottles ( ) 5-6 bottles ( ) 7+ bottles

**By signing below, you agree to the following:**

I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health history.

Client Name (printed) :

Client Name (signature): Date:

Therapist: Date:

# Body Sculpting
# CLIENT CONSENT FORM

Touch of Beauty & Relaxation 4ever INC

Body sculpting increases flow of both the lymphatic and circulary systems, and it helps with cleaning of the tissues. Please be aware that this is not a weight loss treatment, but an inch loss. The main use of body sculpting treatments besides inch loss is diminishing of cellulite, and tightening of the skin. You can lose 1-3 inches per treatment but benefits may be delayed for some people. The inches will return if the client goes back to their old habits. Eating the right types of food, proper exercise, and drinking 8 glasses of water per day are always recommended. It is also recommended to avoid sugar and alcohol for 2 days after treatment. For maximum results a series of 9-12 treatments is recommended. Some may require more treatments.

**Precautions:**
You are not allowed to do treatment if you are pregnant, breast feeding, have a lymphatic disorder, acute illness, metal implants, pacemakers, or are currently being treated for active cancer.

It is impossible to list every potential risk and complication. By signing this consent form you agree to have been informed of possible benefits, risks, and complications including but not limited to: redness, swelling, irritation, pain, increased heart rate, increased bowel movements, increased urination.

You also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that you may require further treatments of the treated areas to obtain the expected results at an additional cost.

The treatment is non-invasive and you should feel no discomfort. You need to notify your technician immediately if you feel any discomfort.

You are advised to speak to your doctor prior to making any decisions about altering any medical regimen you are currently following, changing your diet, taking supplements, or going on an exercise and/or weight loss program. Getting your doctor's approval prior to starting any treatment is solely your responsibility.

I hereby consent to and authorize _____ to perform the following procedure: _____.

# BODY SCULPTING CLIENT CONSENT FORM



Please initial each statement:

_____ I understand there are no guarantees as to the results of this treatment.

_____ I understand that to achieve maximum results a series of 9-12 body sculpting treatments are recommended per area.

_____ I understand that I should consume a healthy diet and exercise regularly to achieve optimal results.

_____ I understand that if I feel any sort of discomfort during treatment I will notify my technician immediately who will then stop the treatment.

_____ I have been informed and understand that if I choose to continue treatment with discomfort it is at my own risk and I will release technician of all responsibility.

_____ I do not have any of these conditions: lymphatic disorder, cardiac issues, acute illness, metal implants, pacemakers, or are currently being treated for active cancer.

_____ I am not pregnant nor am I breast feeding.

_____ I have been informed of potential risks and side effects including but not limited to: redness, swelling, irritation, pain, increased heart rate, increased bowel movements, increased urination.

_____ I have had the opportunity to ask questions about risks and complications.

_____ I understand that photographs and measurements will need to be taken in order to review and record results and will be kept in client file.

_____ I certify that I am over the age of 18.

My signature acknowledges that I agree to receive the treatments or series of treatments listed and that I will adhere to all of the aforementioned statements that I have initialed. I fully understand the risks and side effects associated with the treatment and voluntarily accept these risks. I agree that neither the service provider, it's staff, or any of it's partners will be liable for any injury, including, but not limited to, personal bodily injury, death, mental injury, economic loss or any damage to me, my spouse, or relatives resulting from any act of the service provider.

Client Name (printed) :

Client Name (signature) : Date:

Date:

Therapist :

*Body Sculpting*

# MEASUREMENT TRACKING & TREATMENT CHART

Touch of Beauty & Relaxation Forever INC

## PERSONAL INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ Height : _____

Sessions purchased: _____ Treatment area: _____

Price: _____ Payment plan: _____

Amount owed: _____ Payment type: _____ Final payment date: _____

Notes: _____

| | Chest | Waist | Hips | Weight | BMI | BF% | VF |
|---|---|---|---|---|---|---|---|
| **VISIT 1** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 2** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 3** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 4** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 5** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 6** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |

# BODY MEASUREMENT TRACKER & TREATMENT CHART

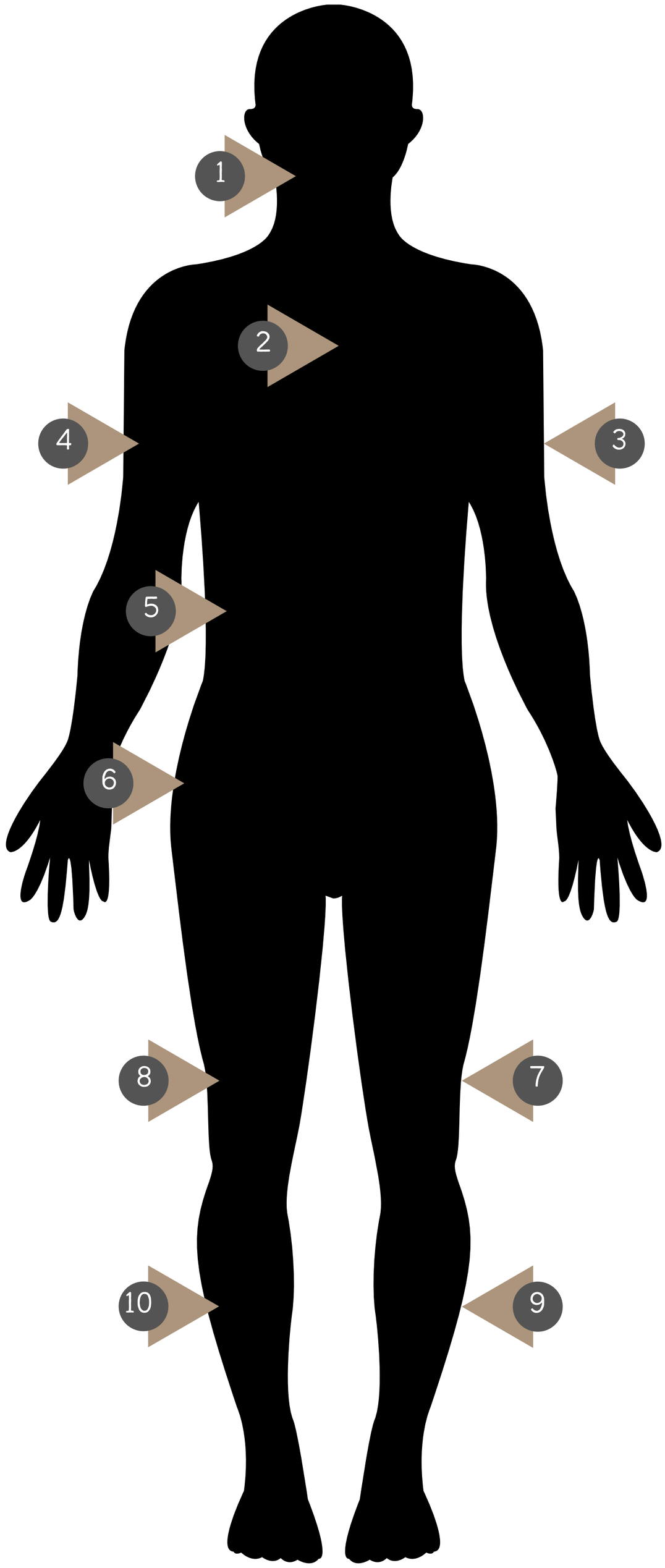
Name: _____ Date of birth: _____

| | Chest | Waist | Hips | Weight | BMI | BF% | VF |
|---|---|---|---|---|---|---|---|
| **VISIT 7** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 8** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 9** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 10** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 11** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 12** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 13** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 14** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 15** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |
| **VISIT 16** **Date:** ___ / ___ / ___ | | | | | | | |
| | | | | | | | |

Touch of Beauty & Relaxation Forever INC

# BODY MEASUREMENT

| BEFORE | | |
|---|---|---|
| DATE: | | |
| WEIGHT: | | |
| 1 | NECK | |
| 2 | CHEST | |
| 3 | LEFT ARM | |
| 4 | RIGHT ARM | |
| 5 | WAIST | |
| 6 | HIPS | |
| 7 | LEFT THIGH | |
| 8 | RIGHT THIGH | |
| 9 | LEFT CALF: | |
| 10 | RIGHT CALF | |




| AFTER | | |
|---|---|---|
| DATE: | | |
| WEIGHT: | | |
| 1 | NECK | |
| 2 | CHEST | |
| 3 | LEFT ARM | |
| 4 | RIGHT ARM | |
| 5 | WAIST | |
| 6 | HIPS | |
| 7 | LEFT THIGH | |
| 8 | RIGHT THIGH | |
| 9 | LEFT CALF: | |
| 10 | RIGHT CALF | |

*Body Sculpting*

# PHOTO AND VIDEO RELEASE FORM

I, _____ hereby grant and authorize _____ the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and /or audio taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph or recording.

I understand and agree that these materials shall become the property of _____ and will not be returned.

I hereby hold harmless and release _____ from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

Disclaimer: If you would like to hide any body features, or identifiable features please address where or which ones you would like to exclude. Facial recognition is also not required and may be removed with any photograph or recording.

_____

_____

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.

Client Name (printed) :

Client Name (signature) : Date:

Body Sculpting

Touch of Beauty & Relaxation 4ever INC

# COVID-19 LIABILITY WAIVER & RELEASE FORM

I am aware that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. And I understand that COVID-19 is extremely contagious and believed to spread through person-to-person contact.

**Please respond to the following questions truthfully and to the best of your ability.**

Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms?

- Fever
- New loss of taste or smell
- Cough Chills
- Fatigue Head or muscle aches
- Shortness of breath Nausea, diarrhea, vomit
- Difficulty breathing Congestion or runny nose
- Sore throat, Body or muscle aches

Yes ☐ No ☐

In the past 14 days, have you or anyone in your household traveled outside of _____?

Yes ☐ No ☐

In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19?

Yes ☐ No ☐

Have you been tested for COVID-19 and are waiting to receive test results?

Yes ☐ No ☐

## RELEASE AND WAIVER

By signing this agreement, I voluntarily assume the risk that I may be exposed to or infected by COVID-19.

I hereby release and hold harmless _____ , from any and all liabilities related to COVID-19 exposure. EVEN IF ARISING FROM THE NEGLIGENCE, ACTS OR OMISSIONS OF THE RELEASED PARTIES.

Print name:

Signature: Date:

Body Sculpting

# APPOINTMENT CANCELLATION POLICY

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

Time has been specifically reserved for your appointment, procedure, or treatment.
If you need to cancel or reschedule your appointment you must call at least 24 hours prior to your appointment. However, providing less than 24 hours' notice will require you to pay a $25 cancellation fee.

If you arrive more than 15 minutes late for your appointment it is considered a no-show and you will be charged the cancellation fee.

We are happy to answer any questions regarding this cancellation policy.

**I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.**

Client Name (printed) :

Client Name (signature) :

Date:

Touch of Beauty & Relaxation 4ever INC

# Body Sculpting

## REFER A FRIEND

## 50% OFF NEXT SESSION

*Book 10 Sessions Bundle*

## GET ONE FREE

REVIEW US!