

INFORMED CLIENT CONSENT FORM

I _____ agree to participate in the health services with the understanding that the counseling and the treatment/care provided, are for my own lifestyle guidance, education and/or relaxation I acknowledge that the service(s) of any one, and/or all of the following: Acupuncture, Reflexology, Ear Candling, Iridology, Emotional Freedom Technique, Muscle testing, Cosmetic Facial Acupuncture, VoiceBio, Ion Cell Cleanse and/or any other modality that I participate in, are not intended for the purpose of diagnosing or treating a specific ailment. I understand that there may be medical conditions that may be adversely affected by the use of the Ion Cell Cleanse, see following paragraph.

I understand that it is not recommended to use the Ion Cell Cleanse if I have any one of the following; open wounds on my feet, type 1 diabetes, currently receive radiation and/or chemotherapy, have a pacemaker/battery operated or electrical implant, organ transplant recipient, organ removed/especially colon, pregnant or breast feeding, heartbeat regulating medication, taking medication the absence of which would mentally or physically incapacitate you, metal implants/knee/hip etc. Though not dangerous, people having a metal joint implant may find exposure to the electromagnetic field generated by the Ion Cell Cleanse to be uncomfortable.

If you choose to do the Ion Cell Cleanse with any of the above mentioned issues then you acknowledge that you have been advised against the treatment but you have chosen to do the treatment of your own free will and do not hold the practitioner liable for any adverse results that may occur.

I acknowledge that should I take the advice/suggestion(s) given by the practitioner, it is my responsibility to check with my own medical doctor before commencing.

With Acupuncture, I understand that there is a possibility of bruising or minor bleeding from the treatment. Cosmetic Acupuncture can not predict the actual outcome or how long the effects will last. I understand that I do not have any of the contraindications for Cosmetic Acupuncture mentioned by the practitioner.

I attest that the information I have provided is true and complete to the best of my knowledge. I also understand that the information I have provided is confidential and will not be released without my consent.

I acknowledge that the practitioner is not a licensed medical doctor or medical practitioner and I therefore take full responsibility and release the practitioner from liability with respect to any advice or treatment/care which I may follow of my own free will.

I acknowledge that by signing this disclaimer once, it will cover all subsequent visits within one calendar year.

Signature _____ Date _____

(Legal Guardian)

Date of Birth _____

Print name _____

Address _____

City _____ Prov. _____ Postal Code _____

Home # _____ Business # _____

E-mail _____ Fax # _____