NAME: _____ DOB: _____

Personal Health & Wellness Consultation Waiver

Please initial each box, indicating that you have read, understand and agree with the statement.

_____ I fully understand that the attending practitioner is not an allopathic practitioner (Medical Doctor) and does not portray his/herself to be one but is a wellness consultant and Sonridge Analyzer practitioner.

_____ I fully understand the difference between the practice of allopathic (conventional) medicine, nutritional wellness consulting, and Sonridge Analyzer scans.

_____ I fully understand that the services provided by the attending practitioner are not allopathic but are strictly bio-electric in nature.

_____ Any reference to patient within this therapy is solely due to technical terminology and in no way implies that the client is a medical patient.

_____ I fully understand that the attending practitioner performs his/her services within the parameters of a natural health care and wellness system using the Sonridge Analyzer and stress reduction.

_____ I fully understand that the attending practitioner does not offer allopathic drugs, surgery, chemical stimulants, radiation therapy, or any other conventional treatments. In addition, he/she does not diagnose, treat, or otherwise prescribe for any disease, condition, or illness.

_____ I have solicited the attending Sonridge Analyzer practitioner's service in good faith, exercising my free will and following the dictates of my own conscious which allows me to select what I understand is most beneficial to my health.

_____ If I desire any services not provided by the attending Sonridge Analyzer practitioner, which is my prerogative, I fully understand that I should seek them elsewhere. A referral for such services can be arranged.

_____ I presently seek council, advice, opinions, Sonridge Analyzer or points of view and/or programs within the scope of the attending practitioner's wellness and stress reduction practice. I am fully aware and release the Sonridge Analyzer practitioner to do Sonridge Analyzer sessions.

_____ I fully understand that the services provided by the attending practitioner are not generally accepted and/or recommended by allopathic doctors (Medical Doctor) or other conventional health care professionals. I realize that insurance payment is not possible, and I understand that payment is expected at the time of service.

_____ By signing below, I acknowledge that I have read and understand all parts of this waiver and that I have had the opportunity to ask questions regarding all such procedures.

_____ The Food and Drug Administration has not evaluated these statements. This product is not intended to diagnose, treat, cure or prevent any disease.

_____ I further affirm that I am not acting in any capacity other than a natural person desiring a Sonridge Analyzer session. I further affirm that I am not acting as an agent for the American Medical Association, or any National, State or Local healing arts group. I further state that I am not an employee of, agent for, or in any way associated with a Foreign, Federal, State, or Local Entity and am acting solely for myself in requesting and taking part in this session or series of sessions. I further affirm that this session will not be used as an entrapment for any government, association, organization or given individual.

_____ With the acceptance of this Consent Agreement, I hereby waive and release myself and my heirs, executors and administrators, from any and all claims of any nature herein and do acknowledge that I will use the services provided at my own risk. I confirm that I have given accurate directions and that I am of legal age in this jurisdiction.

By signing this document, I acknowledge I have read each statement entirely and agree to the statements aforementioned.

Printed Name_____ Witness _____

Signature_____ Date _____

Date_____

Guardian Relationship – If the client is under the age of 18 years of age_____