

# Breathe Salt Wellness---

# PEMF

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of parent/guardian (if applicable) \_\_\_\_\_

What brings you in for PEMF therapy today?

**Ailments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Symptoms began:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Waiver**

Breathe Salt Wellness (operates under Advantage Commerce Inc.) offers time on the Swiss Bionic PEMF (Pulsed Electromagnetic Field) mats to optimize the body's natural self-healing and self-regulating functions, as well as salt therapy.

I fully understand that Breathe Salt Wellness does not diagnose, treat or prescribe for palliate or prevent any disease, ailment, pain, injury, deformity, physical or mental conditions. Breathe Salt Wellness offers a variety of health promoting services which is complimentary and supportive to any medical care, I may be receiving. I understand that any protocol, procedure, and recommendations are designed to promote a greater level of self-care and good health. I fully understand that, according to some scientific opinion, the services offered may be considered to be an inexact science with many variables and that the results may not always be predictable.

I have been informed about the following precautions to treatments on the PEMF mats; pregnancy, pacemakers, implanted pain modulators, insulin delivery system or defibrillators, (because these devices have battery operating systems, and magnetic field exposure may shut them off). Client with Myasthenia gravis conditions with active bleeding, and or epilepsy has fully disclosed their health conditions with each visit and Omnium mask is not recommended.

In consideration of Breathe Salt Wellness permitting me to participate in these activities, and permitting me use of their equipment and facilities, I hereby agree as follows;

To waive any and all claims, to hold harmless and to release Breathe Salt Wellness clinic and Advantage Commerce Inc, their shareholders, stakeholders, and its employees, subcontractors, volunteers, and representatives from any and all liability for any loss, damage, injury or expense that I may suffer or that my next of kin may suffer, as a result of my participation in activities offered by, or associated with Breathe Salt Wellness due to any cause whatsoever, including negligence, breach of contract, breach of statutory duty of care, and/or breach of the occupier's liability act, in the part of Breathe Salt Wellness, its employees, subcontractors, volunteers, and representatives.

I take a full responsibility for any decision, choice or action that I take as a result of Breathe Salt Wellness' services. I have read and understand this agreement prior to signing it.

Please note; you are advised to consult a physician prior to adjusting or stopping any prescribed medication.

**24 hours notice** is expected for cancelled appointments, or \$27.50 session will be charged in your next visit.

Dated this date: \_\_\_\_\_ day of of Month \_\_\_\_\_, Year \_\_\_\_\_

Signature \_\_\_\_\_ parent/guardian \_\_\_\_\_