I understand that the following services are not diagnostic and received under no direst. By signing below, I acknowledge that I am releasing responsibility from the practitioners. I am choosing to participate in these services under my own free will. I am not being forced into any therapy and will not find the therapists responsible for any outcomes of the therapy. I take full personal responsibility for my own wellbeing and health. I have also been given the opportunity to ask questions regarding each individual therapy.

Limbic Stress Assessment (LSA) Scan: I have been informed about the therapist and procedure:

- The Technology being utilized in these testing procedures was not designed for, nor being used as diagnostics.

- I understand that no warranty or guarantee has been made to me as the result of these procedures.

- It is possible to experience a healing reaction from the recommendations that follow the procedure.

- It is my responsibility to inform the technician/ practitioner of any and all medications I am taking.

- I understand that though there may be references to body tissue, organ, or organ systems during the course to the session and thereafter, these references are made only in their association with the energetic conductivity of their related meridians (energy pathways).

- I understand that this practice is not presented to me as an alternative to any kind of healthcare. It is presented to me in cooperation and conjunction with any other healthcare decision that deem necessary or appropriate. It does not replace the advice or recommendations received form my personal healthcare practitioner. If I suspect any medical intervention, I will consult my own physician.

- I understand that the technician/ Practitioner is not my primary care physician.

- I understand recommendations for supplementation comes from the evaluation from the LSA Body scan. These recommendations are not to replace any medications from my medical provider, but are to work in-hand with the medical providers' recommendations.

- Any decision to follow through with the protocol is my own choice.

Initial _____

Foot Zone Therapy: I have been informed about the Foot Zone Therapist and therapy:

- Therapist is not a Doctor.

- Does not practice medicine.

- Does not diagnose or treat for specific illness.

- Does not prescribe or regulate medication.

- Is not a substitute for medical treatment, but is a complement to most types of therapy.

By initialing below I give consent to a foot zone session. I understand that I may discontinue this session or future sessions at any time. If I have been diagnosed by a licensed health professional as having any disease, injury, or other physical or mental condition I understand that I should inform the person who made the diagnosis about the sessions you will be receiving, and whether or not you intend to discontinue any treatment or therapy which had been previously ordered, prescribed, or recommended by a licensed health professional. I understand that by discontinuing any such treatment or therapy, I assume responsibility for any negative outcome resulting from discontinuing that treatment or therapy.

A Foot Zone Practitioner may not diagnose disease, injury, or disfigurement. Only licensed health professionals may perform diagnosis. The Foot Zone Technique is not a substitute for medical care. If I am experiencing any specific medical problem and have not seen a medical doctor, I understand that it is recommended for me to see a physician today. If I am unsure of the nature of the condition, I have been encouraged to consult an appropriate licensed health care professional such as a physician.

Initial _____

Ionic Foot Bath: I understand the following information about the Ionic Foot Bath.

- I certify that I am not on any heartbeat regulation medication.

- I have not had an organ transplant.

- I am not taking any medications that the absence of would mentally or physically incapacitate me.

- I am not pregnant or nursing

- I understand the risks and take full responsibility for any consequences or side effects that might follow.

Initial: _____

Massage Therapy: I have been informed that a Massage therapist and Therapy:

- Does not diagnose illness, disease, or another physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulation.

- Does not substitute for medical examination or diagnosis and that it is recommended that I see a physician for any ailment that might concern you.

- Does not offer any services involving sexual stimulation. Any requests for such will result in the discontinuation of the massage with full payment for the time reserved.

- I also understand that massage in its various forms is given here for the purpose of stress reduction, for increasing circulation or energy flow, and for the relief from muscular tension, spasm, or pain.

- I also understand that information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion.

- I take it upon myself to inform the therapist of any physical, mental, or emotional conditions that I am aware of at the time of the massage and take it upon myself to keep the therapist updated on my health.

By initialing below I give consent to the Massage.

Initial _____

Colon Hydrotherapy: I have been informed on Colon Hydrotherapy and the Therapist.

- I understand Colon Hydrotherapy is an invasive procedure.

- I understand that colon Hydro-therapist is licensed

- The therapist is not a Doctor

- The therapist cannot prevent, treat or diagnose.

- The Therapist will be in the room through the whole procedure.

- Once the procedure has started I cannot opt out without allowing the therapist to finish flushing the bowls.

- The therapist has the right to use massage and reflex points on the body.

- I have the responsibility to inform the therapist of any discomfort, pressure, feeling faint, or another emotion, feeling, or discomfort that changes during the procedure.

- I take full responsibility for any side effects that occur after the therapy.

- If I have any symptoms that occur I understand it is my responsibility to seek after medical assistance.

By initialing below I give consent for Colon Hydrotherapy.

Initial: _____

Emotional Balance: I have been informed about the Emotional Balance and the Therapist.

- I request and consent to the performance of energy healing modalities and therapies within the scope of the practitioner.

- I understand methods of therapy may include but are not limited to: energy balancing and harmonizing, visualizations, energy medicine routines and education, and education about spiritual benefits and healthy life.

- I will immediately notify my energy practitioner of any unanticipated or unpleasant effects associated with any of the energy modalities applied.

- I have been informed that Energy medicine is generally safe method of treatment. I have been notified that energy shifts may occur and create some physical, emotional, or spiritual side effects (Muscle soreness, tingling, headaches, changes in relationships, mile fatigue, energy movement, etc.).

- I understand that all sessions will be kept confidential among the practitioners in First Step to Wellness Clinic.

- I take personal responsibility for my well-being and with respect for myself I gratefully accept control of my choices. My heirs, guardians, legal representatives, and I hereby and forever release, waive, and discharge any claims against the Energy Balance Practitioner.

- I take full responsibility and am responsible for all liabilities for loss or injury incurred while in association with or applying energy techniques and information learned from the Energy Practitioner (Susan Loveland)

By initialing below I give a waver and release of potential liability.

Initial _____

Far Infrared Sauna: I have been informed about the Far Infrared Sauna.

-I understand that this is not a treatment, cure, or preventative therapy.

- I understand I am not to use the Sauna if I am under the influence of alcohol or drugs

- I understand that I am not to use the sauna if I am pregnant.

- If I am on any prescription drugs I need to consult my physician before use.

- I am responsible for my personal belongings while in the sauna.

- Any expenses due to injury received while in a sauna session will be my responsibility and not the clinics.

- I will not eat or drink while in the sauna.

- I will not exceed the allotted time for the sauna session of 45 min.

- I understand the following benefits to the Far Infrared Sauna do not apply to each individual user of the sauna: increase circulation, burn 600 calories in 30 Min, break down of cellulite, helps Arthritis issues, helps the cardiovascular system, detoxes the body, fights bacteria and virus, increases flexibility, pain relief, and relaxation and rejuvenation. Every benefit is on an individual basis.

- I understand it is my responsibility to ensure I have been properly hydrated before each sauna use to help prevent dehydration.

I have been informed and give consent by initialing below.

Initial _____

Laser/Radionics/Sweep/Light Therapy: I have been informed on the Laser/Radionics/Sweep/Light Therapy and the therapist.

-I understand this practitioner is not a medical doctor.

- I understand this practitioner does not treat, prevent, cure, or diagnose.

- I understand this therapy can cause feelings that are not limited to weakness, dizziness, fatigue, headaches, blurred vision, etc.

- I understand it is my responsibility to inform the practitioner of any symptoms that occur during or from the therapy.

- I understand that any discussion during the therapy is solely for my benefit and is not to be taken as counseling or any form of treatment, diagnosis, or cure, and is for me to use as I see fit.

- I do not hold the practitioner or clinic responsible for any injury or harm that may occur during this session.

By initialing below I give consent to the therapy.

Initial _____

Dark Field Microscopy: I have been informed on Dark Field Microscopy and the Therapist.

-This procedure is not a diagnostic test.

- The therapist is not a medical doctor and does not diagnose, treat, cure, or prevent disease.

- This procedure does require a drop of blood from your finger.

- The therapist will discuss what they see in the blood. They have been trained for this specific procedure, but the things discussed are for personal information and not for diagnostic purposes.

Presently, dark field blood microscopy is the only way to observe live blood cells. Practitioners take a small amount of blood from a patient, apply the sample to a slide and observe the blood. Most blood-microscopes come equipped with a camera and video equipment, allowing both the practitioner and patient to view the specimen together. In addition to red blood cells (RBCs), white blood cells (WBCs) and plasma, blood microscopy is believed to show items within the plasma such as: Undigested food particles, Fungus, Crystals, Microbes, Bacteria. Many Practitioners also claim to observe pleomorphic activity, the condition of major organs, mal-absorption of proteins, lipids and nutrients and immune system disorders.

By initialing below I give consent for the therapy.

Initial: _____

I certify that I have read, fully understand, and agree to the above information, the element of informed consent, my responsibilities and rights, and give my consent. I have been informed on each practice, procedure, or therapy and give informed consent to the therapists for their therapies. I also take full responsibility and am responsible for all liability, for loss, or injury that may occur while in any of the therapies participated in during the clinic week. I do not hold the therapists legally responsible. I take full responsibility for my own care after the clinic and am fully responsible for supplementation that I may choose to purchase of my own free will. I agree that this agreement shall be governed by, constructed, and enforced in the accordance with the laws and State of Idaho and subject of the jurisdiction of the First Judicial District of the State of Idaho in and for Madison County. I also understand the financial responsibility for payment for the procedures and any protocol that I choose to follow. All procedures will be paid for in full before they are received and any product protocols are required to be paid in full before they can be picked up. I give my informed consent to use each therapy recommended.

Name (Printed): _____ Date:_____

Signature: _____

Signature of Legal Guardian (If needed) :_____

Address: _____ City: _____

State: _____ Zip Code: _____

Phone Number: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____