INFORMED CONSENT FOR FREQUENCY DEMO, THERAPY, TRAINING

Independent OlyLife Distributor Name: Christa M. Emrick

Phone: 210-710-4793 Web: Christa@olylifeglobal.com

Client Full Name:_____

Birth Date:_____Phone:_____

Email:_____

Please answer the following questions:

Do you have a pacemaker or any type of implanted device? **YES_____ NO_____

Can you turn off your implanted device? YES_____ **NO_____

Are you pregnant? **YES_____ NO_____

Do you suffer from a Hemorrhagic Disease? **YES_____ NO_____

****Contraindications.**

Implants must be turned OFF before use. It is my responsibility to avoid any contraindications and, if I have an implanted device, it is my responsibility to turn it OFF before use.

CLIENT CONFIDENTIALITY

I,_____, understand any information provided to the Independent OlyLife Distributor is confidential and will not be shared with anyone, EXCEPT when specifically required by law or when I give written permission on a separate document. I have the right to withdraw this permission at any time.

DISCLAIMER

I understand that the Independent OlyLife Distributor cannot diagnose, cure or treat, those issues, diseases, disorders, or conditions and will not go outside of her scope of practice. I understand that frequency Therapy/Training may be an adjunct or complement, not a substitute,

for medical or psychological treatment; and any ongoing medical treatment should not be discontinued without the advice of my treating physician.

CLIENT AGREEMENT

I consent to receive Frequency Therapy/Training from the Independent OlyLife Distributor**.** I understand my health and wellness is my responsibility. Therefore, I agree to use the services offered by the Independent OlyLife Distributor to help me learn how to manage my health and wellness better. I further understand that I can discontinue Frequency Therapy/Training at any time and may decline any particular Frequency Therapy/Training at my sole discretion.

Furthermore, I understand that I accept any liability for my experience with frequency technology, and I may work with a professional or consultant for more feedback and education only. I understand that my actions are my responsibility, and it is also my own responsibility to avoid any possible contraindications.

I also understand that it is my responsibility to avoid any contraindications and, if I have an implanted device, it is my responsibility to turn it OFF before use.

By signing below, I acknowledge I have read and understand this document, and I have received acceptable answers to my questions about Frequency services from the Independent OlyLife Distributor.

CONSENT

My signature below indicates that I have read and understand the information in this document and that I consent to Frequency therapy under the provisions stated. If I do not understand or consent to anything stated in this document, it is my responsibility to request and receive clarification before signing below.

Client Signature_____Date_____

IF CLIENT IS A MINOR, PARENT/GUARDIAN MUST SIGN BELOW

I attest that I have the full legal authority to make decisions for the minor named above and that I give my permission for him/her to undergo Frequency Therapy/Training.

Parent/Guardian Signature_____Date_____

Minor's Name:_____