

**Vitalistic Health Spa Halogenerator
Intake and Waiver Form**

Name _____

Address _____

City _____ State _____

Zip _____ Phone # _____

Email _____

Would you like to receive our newsletter and other information? Yes No (We do not distribute or sell any of our customer information and you may unsubscribe at any time)

Birthday: _____

Do any of the below conditions apply to you (or your child) please circle:

Allergies Dermatitis Rhinitis Asthma Ear Infection Psoriasis Bronchitis Sinusitis
Cold & Flu Eczema Sleep Apnea/Snoring Cystic Fibrosis Emphysema Smokers Cough
COPD Hay Fever Stress

Other health conditions please list _____

Salt Therapy (also known as Halotherapy) is a passive respiratory therapy wherein the client inhales dry salt air, emitted by a machine known as a halogenerator. The aerosolized salt is drawn into the sinus cavities and bronchial passages through normal breathing, potentially relieving inflammation and other respiratory symptoms associated with conditions such as allergies, asthma, etc. Salt Therapy is neither a medical treatment nor a replacement for medical care. If you have a medical condition that requires treatment, you should consult your primary care physician. Always consult your primary care physician before making any adjustments to your medication schedule. The Salt Spa staff make no medical recommendations or medical advice regarding any illness or condition. The halogenerators are not approved by the federal Food and Drug Administration ("FDA") as medical devices for diagnosis or treatment of any disease or condition. They are approved for sale in the United States as air filtration devices. Severe Allergy, Asthma and COPD Clients If you suffer from severe allergies, asthma or COPD you may need a gradual introduction to Salt Therapy. It is important to set your own pace in this therapy. If at any time during your salt therapy sessions you feel especially uncomfortable, and are having difficulty breathing, you are advised to step out of the salt room and seek out a staff member for assistance. We will work with you to schedule your salt therapy sessions considering your condition and reaction. Release; Assumption of Risk; Consent to Participation Salt therapy is not intended to diagnose, treat, cure, mitigate, or prevent any disease. I understand that it is my responsibility to consult my primary care physician or appropriate, licensed health care practitioner for all my health concerns. I understand that no representations, claims or guarantees are being made as to any medical or therapeutic benefit. For good and valuable consideration, the receipt of which is hereby acknowledged, I hereby release, indemnify, defend, protect, and hold harmless Vitalistic Health Spa, Vitalistic Health Spa LLC and all its employees, independent contractors, shareholders, officers, members, agents, and affiliates (collectively, the "Released

Parties”) from any and all claims I may have against them relating to my participation in salt therapy. I knowingly, voluntarily, and expressly assume all risk of participation in salt therapy and agree not to bring any legal claim against any of the Released Parties based on such participation.

NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ AND FEEL YOU UNDERSTAND IT. PLEASE ASK ANY QUESTIONS YOU HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE. I certify that I have read the foregoing, discussed the issues noted above, had opportunities to ask questions, and agree to and accept all the terms above.

Client Name: _____ Date: _____

Signature: _____

If signing for someone else, please indicate your name and relationship to the client:

Name: _____ Relationship: _____

I am the parent or legal guardian of the minor named above. I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this Release and Waiver of Liability.

Parent of Child’s Signature: _____

Parent of Child’s Name: _____

OFFICE USE: Witness: _____ Date: _____