NEW CLIENT WAIVER

Date: _____

To: Julie Formby at New Vitality, LLC

To establish and clarify my purpose in coming to you for a consultation, I want to clearly state that my interests are in learning how to establish a good nutritional program and in learning about new lifestyle habits. I understand that it is my personal decision as to whether or not I follow the program that you suggest.

I completely understand that you are not a medical doctor and that this program does not replace the advice of a physician. I understand that your advice is not meant to conflict with the recommendations of doctors or practitioners who are licensed by state and/or federal laws. I understand that I have the right to choose alternative methods of health treatment for myself and that, if I do so, I accept full responsibility for my actions.

I understand that you do not diagnose disease; that you do not treat disease; that you do not make recommendations that will treat a disease that I have already been diagnosed with.

I fully understand that you recommend I visit a licensed physician if I have serious health problems, and that I should consult this physician before I make any changes in my diet.

I have been informed about the benefits of using Action Lymphatics 2-probe (AL2) Light Beam Generator, and I understand that cold gas, coherent, photonic energy powered by direct current pulses of energy with FM modulation can aid with:

- ☐ Lymphatic drainage
- ☐ Removal of toxins
- ☐ Limitation and inhibition of the development of viruses, fungus, and bacteria
- ☐ Balancing the electromagnetic field of my body
- ☐ Restoring a tranquil state in my body (1) User Manual: Action Lymphatics 2; ELF Labs Technology; 2013; p. 3

I understand that the benefits of the infrared technology on this device may include:

- ☐ Pain relief
- ☐ Reduction of swelling & inflammation
- ☐ Acceleration of wound healing
- ☐ Decrease in scar tissue
- ☐ Enhanced cellular functions
- ☐ Increased lymphatic activity (2) Ibid. p. 7.

I am aware of the following contraindications for use with the Light Beam Generator and verify that <u>none of the following statements are true</u> about me, to the best of my knowledge. Please check all statements that are TRUE:

- ☐ I am not pregnant
- ☐ I do not have a history of epilepsy or seizures

- ☐ I do not wear a pacemaker
- ☐ I do not take blood thinning medications
- ☐ I do not have a known thrombosis (blood clots)

- ☐ I do not have a hyperactive thyroid
- ☐ I am not currently experiencing asthma symptoms
- ☐ I am not menstruating
- ☐ I understand that use of infrared light in the eye area should be done with eyelids closed (3) Ibid. p.22

Additionally, I understand that:

- ☐ It is important that I am fully hydrated before and after using the Light Beam Generator in order to aid lymphatic drainage and waste removal from my body (4) Ibid. p.19
- ☐ I may experience nausea, dizziness, and/ or headaches as a result of using this technology (5) Ibid. p. 19

I agree to give you a 24-hour notice, if for any reason, I need to change or cancel an appointment. If I am unable to give this notice, I am fully aware that I will be charged an office fee.

Respectfully yours,

Signature _____

Printed Name _____

Address _____

City _____ State _____ Zip _____

Phone: Day _____ Evening _____

I am a legal guardian to a minor and accept responsibility for this consultation. My signature acknowledges that I have read and understand all of the above information.

Guardian's Signature _____

Minor's Printed Name _____