



## SolaJet Drywave Soft Tissue THERAPY

### CONTRAINDICATIONS FOR SOLAJET

Published research shows that there are no contraindications established currently SolaJet therapy, when following manufacturers user Instructions. Nonetheless, caution must be exercised with sensitive areas or if the patient should not be receiving any form of soft tissue treatment.

### CONSENT TO SolaJet Therapy

The signature made below is an acknowledgment that: 1) I have read and understand the information about SolaJet Therapy as provided either in writing, verbally in person or online. I have been given an opportunity to ask questions and I have received all information I desire about the therapy I will receive.

I hereby give my authorization and consent for the administration of SolaJet therapy. I agree that I will comply with all instructions on the use of the SolaJet Device.

This CONSENT shall stand as long as I use the Equipment at the location now and in the future

I acknowledge that I am making an informed decision to assume risk, known and unknown, as to any damage or harm that I might incur due to use of the facilities. Because Massage should be avoided under certain conditions, I agree to keep the staff updated on any changes in medical conditions and understand that there shall be no liability on the staff's part should I forget to do so.

\_\_\_\_\_  
CLIENT NAME – PLEASE PRINT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Client Signature (Parent/Guardian signature required if under 18)



## Spectrum LED Photobiomodulation

**Photobiomodulation Therapy** is a form of low dose light treatment that has been shown to reduce pain or inflammation and promote healing. PBM uses light to selectively inhibit pain receptors or promote resolution of inflammation. It is also able to stimulate the inherent tissue healing and regeneration responses in the body. It has been shown to improve muscle performance and joint motion, by reducing inflammation wherever the light is applied. Treatments typically take between 12 to 20 minutes and is repeated up to three times a week.

Published research shows that there are no contraindications Nonetheless, caution must be exercised for persons in these categories:

**PREGNANCY:** Whole body PBM therapy should be avoided in pregnant women. However, local PBM treatments may be used with caution on the pregnant woman to manage back pain or other complaints. **CARCINOMA:** Direct treatments on tumors are not recommended. However, application of PBM in other areas of pain is known to benefit supportive cancer care. Any PBM treatment must be performed in consultation with the oncologist, care-givers. **PHOTOSENSITIVITY REACTIONS:** Some patients are known to be more photosensitive, and some drugs or natural remedies are known to exacerbate these reactions. A detailed history and careful observation after the first PBM session is recommended. In rare instances, even local treatment may be contraindicated. **FILLERS/PEPTIDES:** Individuals should refrain from using Spectrum therapy for 3 days after receiving fillers and 24 hours after peptide treatments.

### PRE-SESSION INSTRUCTIONS

- It is not recommended to use lotions, powders, perfumes or makeup within 1 hour prior to session.
- No prescription glasses or contacts should be worn during the session. PBM recommended goggles should be worn.

**AFTER ANY SESSION:** Avoid Direct UV Light/Sun exposure

## CONSENT TO PBM THERAPY

The signature made below is an acknowledgment that: 1) I have read and understand the information about Photobiomodulation Therapy. I have been given an opportunity to ask the staff questions and I have received all of the information I desire about the therapy and procedure. I hereby give my authorization and consent for the administration of PBM therapy.

I agree that I will comply with all instructions on the use of the PBM devices.

This CONSENT shall stand as long as I use the Equipment at the location now and in the future. I can revoke this consent verbally or in writing or by simply exiting the facility, but I do understand that during use of the PBM panel an attendant may not be instantly available for an immediate verbal revocation/ request to cancel the procedure.

I have read the instructions for proper use of the facilities and do so knowingly. I acknowledge that I am making an informed decision to assume risk, known and unknown, as to any damage or harm that I might incur due to use of the facilities. Because Photobiomodulation should be avoided under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the staff updated as to any changes in my medical profile and understand that there shall be no liability on the staff's part should I forget to do so.

\_\_\_\_\_  
CLIENT NAME – PLEASE PRINT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Client Signature (Parent/Guardian signature required if under 18)



## VITALITY BOOTH HaloRed™ Vitality Booth RELEASE AND WAIVER OF LIABILITY

**BALI HOLISTIC WELLNESS CENTER** (the “Company”), reserves the right to alter or modify the below terms and conditions from time to time. Your acknowledgment below constitutes your agreement to any and all terms changed, modified or altered.

The information contained both herein and on our website is designed to disseminate general information. It is not intended to give medical or pharmacological advice and as such should not be relied upon as a substitute for professional medical advice.

**Halotherapy (“Salt Therapy”)** is not recommended in the following cases: tuberculosis, fever, contagious conditions, severe heart disorders, or existence of cancer, advanced pregnancy, or acute state of respiratory attack. The use of Salt Therapy is not intended to substitute for medical care or treatment. Do not stop your medication without first consulting with your doctor. Salt Therapy does NOT substitute for any conventional medication. If you have any questions about Salt Therapy, check with your doctor before proceeding.

**Red Light Therapy is not recommended in the following cases:** pregnancy, epilepsy, individuals currently taking cortisone injections or steroids, acute and active hemorrhage, or individuals with diseases that involve the retina of the eye, such as diabetes. Use of Red Light Therapy directly over the thyroid in specific thyroid conditions is not advised.

**Medications:** Use of Red Light Therapy while taking photo-sensitizing medications like lithium, melatonin, phenothiazine, antipsychotics, and certain antibiotics is not advised. Talk to your physician for advice on whether or not Red Light Therapy is right for you.

In consideration of being permitted to enter the premises and engage in any of the services offered by the Company (the “Activities”), I, the Client or the Parent or Guardian of the minor child listed below, agree to all the terms and conditions set forth in this agreement (the “Agreement”).

I acknowledge and fully understand that engaging in the Activities involves a significant and inherent risk of loss, damage or injury, including but not limited to physical injury, damage to myself or my property. I acknowledge that I am voluntarily participating in the Activities with knowledge of the danger involved and hereby agree to accept and assume any and all risks of injury, death or property damage, whether caused by the negligence of the Company or otherwise. Furthermore, I acknowledge and understand that:

1. My participation in the Activities is purely voluntarily and no promises, warranties or representations were made to me by the Company to induce me to participate;

2. I am fully responsible for myself and any of my children, guests and/or invitees;
3. The Company does not evaluate or diagnose my health and I have received medical clearance prior to engaging in the Activities;
4. I have been advised of the following possible side effects: Dry or itchy throat, nasal drip, and increased coughing at the beginning. This is a natural part of the cleaning process of the respiratory system, during which the pollution, accumulated through a long time, and now loosened up by the salt, is expelled from even the deepest regions of the lungs. Such side effects should cease with the removal of pollution and pathogens. Skin irritation and dermal sensitivity may occur. In such a case, decrease the frequency of sessions;
5. The Company has neither applied for or received approval by the Food and Drug Administration or any other consumer protection group;
6. The use of the cabin at the Company has not been evaluated by the Food and Drug Administration or any other agency;
7. The use of Red Light and Salt Therapy is not intended to treat, cure or prevent any illness or condition. All medical conditions should be treated by a physician competent in treating that particular condition. The Company assumes no responsibility for customers choosing to treat themselves; and
8. All products and services provided by the Company, including written information, labels, brochures and flyers as well as information provided orally or in any other medium of communication, have not been evaluated by the Food and Drug Administration and are not intended to diagnose, treat, cure or prevent any disease. For all your health concerns, please consult an appropriately licensed healthcare practitioner.

I AGREE THAT NEITHER THE COMPANY NOR ITS MEMBERS, MANAGERS, EMPLOYEES, AGENTS, SUPPLIERS, SUCCESSORS AND ASSIGNS SHALL BE LIABLE FOR ANY DAMAGE RESULTING FROM THE ACTIVITIES. THIS LIMIT OF LIABILITY COVERS CLAIMS BASED ON WARRANTY, CONTRACT, TORT, STRICT LIABILITY, AND ANY OTHER LEGAL THEORY. THIS PROTECTION COVERS THE COMPANY, ITS MEMBERS, EMPLOYEES, AGENTS, AND SUPPLIERS. THIS PROTECTION COVERS ALL LOSSES INCLUDING, WITHOUT LIMITATION, DIRECT OR INDIRECT, SPECIAL, INCIDENTAL, CONSEQUENTIAL, EXEMPLARY AND PUNITIVE DAMAGES, PERSONAL INJURY/WRONGFUL DEATH, LOST PROFITS OR DAMAGES RESULTING FROM USE OF THE ACTIVITIES, THE SALT CABIN OR THE COMPANY'S FACILITIES

I HEREBY EXPRESSLY WAIVE AND RELEASE ANY AND ALL CLAIMS, NOW KNOWN OR HEREAFTER KNOWN IN ANY JURISDICTION AGAINST THE COMPANY, AND ITS MEMBERS, MANAGERS, EMPLOYEES, AGENTS, SUPPLIERS, SUCCESSORS AND ASSIGNS (COLLECTIVELY, "RELEASEES"), ON ACCOUNT OF INJURY, DEATH OR PROPERTY DAMAGE ARISING OUT OF OR ATTRIBUTABLE TO MY PARTICIPATION IN THE ACTIVITIES, WHETHER ARISING OUT OF THE NEGLIGENCE OF THE COMPANY OR ANY RELEASEES OR OTHERWISE. I COVENANT NOT TO MAKE OR BRING ANY SUCH CLAIM AGAINST THE COMPANY OR ANY OTHER RELEASEE, AND FOREVER RELEASE AND DISCHARGE THE COMPANY AND ALL OTHER RELEASEES FROM LIABILITY UNDER SUCH CLAIMS.

All matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the internal laws of the State of **NEW HAMPSHIRE** without giving effect to any choice or conflict of law provision.

BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD ALL OF THE TERMS OF THIS AGREEMENT AND THAT I AM VOLUNTARILY GIVING UP SUBSTANTIAL LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE THE COMPANY.

**Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_**

*For Adult Salt and Red Light Therapy:*

\_\_\_\_\_  
CLIENT NAME – PLEASE PRINT

\_\_\_\_\_  
CLIENT SIGNATURE

*For Child Salt and Red Light Therapy: I am aware that Red Light Therapy is not suitable for a child under the age of 15.*

CHILD'S NAME : \_\_\_\_\_ CHILD'S AGE \_\_\_\_\_

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/GUARDIAN SIGNATURE

\_\_\_\_\_  
PARENT/GUARDIAN NAME (Please print)