OMNI
BALANCED LIFE CENTER

Traditional & Holistic Therapeutic Services

Client Name: _____

MEDICAL DEVICE CONSENT

Please initial beneath each statement below if you are receiving any medical device treatments, including **BEMER** Physical Vascular therapy, **Thermalife** Infrared Sauna, **TAMA** Blue Onyx Micro-current, Optimum Energetics Inonic Foot Detox, Life System Bio-Feedback, Sonicator Ultra Sound, Epiwave Ultrasonic, **BioCharger NG**:

___ I understand that there are always risks associated with any medical device and that I should consult my doctor if I have any of the following: autoimmune disorders, diabetes, embolism, epilepsy, melanoma, metal implants including plates/pins/screws, open wounds, pacemaker use, phlebitis, pregnancy, thrombosis, or varicose veins.

___ I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.

___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

___ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

___ I understand that these treatments cold cause a detoxification reaction in my body including but not limited to headache, dizziness, nausea, vomiting, weakness, though by hydrating and disclosing all medical conditions, medications these reactions are minimized.

TAMA Blue Onyx Micro-current, MPS Dolphin Pens, Epiwave, Ultrasonic
(Please initial beside each statement below ONLY if you are using Micro-current treatment)

___ I understand that micro-current treatments involve conducting mild electrical currents through the body, and that this brings some inherent risk.

___ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

___ I understand that some clients report slight tingling sensations, flashing of the optic nerve, and/or a metallic taste in the mouth during the procedure.

___ I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

___ I give permission to my skin care specialist to perform the micro-current procedure we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment.

I, _____certify that I have read, and fully understand, the above statements and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skin care specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Signature: _____ Date:_____

Omni Balanced Life Center 720 Goodlette Road Suite 205 Naples, FL 34102
Office@OmniNaples.com | 239-234-1608
www. OmniNaples.com