Serenity Salt Cave
& Healing Center

CUSTOMER INFORMATION and LIGHT THERAPY (BRAINTAP) WAIVER FORM

Name_____ Date of Birth_____

Phone_____ Email _____

Address: _____ City _____ Zip_____

Referred by (Name)/How you heard about Serenity_____

Primary reason for Light Therapy (BrainTap) today is: Personal Health_____ Business Interest_____

Are you pregnant? _____ Are you light sensitive? _____

Top areas of concern: _____

_____

_____

Medical diagnosis you have received: _____

WAIVER and RELEASE of LIABILITY

I understand that the attending demonstrators are not allopathic doctors (MDs) and do not portray themselves to be but are providing Light Therapy and wellness services. Procedures utilized include stress reduction therapy, nutritional stress/wellness consultation and Light Therapy. I fully understand that the attending demonstrators do not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments. In addition, we do not diagnose, treat or otherwise prescribe for my disease, illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited the attending practitioners'' services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health. I am fully aware and release the practitioner to do a Light Therapy session, wellness consultation and other stress reduction protocols. By signing below I acknowledge that I have read and understand all parts of this waiver, that I had the opportunity to ask any questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and I am here on this and any subsequent visit solely on my own behalf.

I have read through the entire agreement and consent to its content.

Signature_____ Date_____

Demonstrators use only:

Light Therapy Session Notes: