Client Release and Waiver Form for Alma Holistic Health

By signing below, I acknowledge and agree that:

I am here to learn about holistic health and wellness, holistic nutrition and better health practices and that I will be offered information about food supplements, homeopathy, herbs, reflexology, essential oils, gemstone therapy, energy balancing, flower essences, hydrotherapy, yoga and relaxation techniques as a guide to general good health and this is considered to be for educational purposes only.

I fully understand that those who counsel me from Alma Holistic Health are not medical physicians and do not practice medicine. I am not here for medical diagnostic purposes or treatment procedures. I am not on this consultation or any subsequent consultation working as an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed by Alma Holistic Health are at all times restricted to consultation and coaching on the subject of holistic health, wellness and holistic nutritional matters intended for the maintenance of the best possible state of overall health and wellness and do not involve the diagnosing, treatment or prescribing of remedies for disease.

I also understand that it is my responsibility to discuss any and all information provided during consultations and coaching with my primary health care provider or any other health care providers/specialists whose care I may be under.

I release Lidija Millonig Atlas, Alma Holistic Health, and its practitioners from any and all legal liability during my participation in Alma Holistic Health consultations and coaching. I assume sole responsibility for my own health and for the results of any consultation and coaching provided by Alma Holistic Health that may affect my health in any way.

All information received by me from Lidija Millonig Atlas, Alma Holistic Health, and its practitioners is accepted with full knowledge that any action taken by me as a result of the information received is my complete responsibility

Due to HIPPA privacy regulations, your information will be held confidential and not shared with anyone.

_____ Initial here to indicate that you have been advised of all consultation fees.

_____ Initial here to indicate that you are aware that these services are not covered by insurance and that you are responsible for all fees incurred.

Date.______________ Signature: __________________ Please Print Name:

Signature of Guardian for minor child: _____________