"Rejoice in a Clean Body and Clear Mind"

Client Information

Therapeutic Acupressure, Chinese Cupping Therapy, Health Counseling, , Including but not limited to, Herbs other supplements and essential oils

Personnel Information:

Name_____ **Date**_____

Phone (Day)_____ Phone (Eve)_____

Address _____

City/State/ _____

Zip _____

Email _____ (would you like to be placed on our email list for newsletters information and specials? *****We do not share or sell your information. It will be kept private and confidential. We send out 1-3 emails per month.) (Y) (N)

Date of Birth _____

Occupation _____

Emergency Contact Phone_____

Please Check Selected Service:

Therapeutic Acupressure_____

Chinese Cupping Therapy_____**, Health Counseling, Including but not limited to, Herbs other supplements and essential oils**_____

Number of previous sessions _____

Do you have a particular area of concern? _____

_____

_____

Are you sensitive to perfumes or fragrances? _____

Are you sensitive to touch? _____

How did you hear about us? _____

I _____(print Name) understand that **Therapeutic Acupressure, Cupping Therapy, Health Counseling, Including but not limited to, Herbs other supplements and essential oils** can complement any medical or psychological care I may already be receiving. I also understand that the body has the ability to heal itself and to do so, complete relaxation, and the reduction/dissolution of stressful factors in my life is often beneficial.

I acknowledge that long term imbalances in the body sometimes require multiple sessions in order to facilitate the level of relaxation needed by the body to heal itself. I agree to accept full liability for any adverse emotional, mental or physical outcomes from the session(s) given by Clean Clear Body, Agatha Repice and their practitioners or staff members. I release Clean Clear Body LLC; their practitioners and staff from any liability. I consent to mediation/arbitration to settle any dispute and herby acknowledge and accept treatment sessions.

DISCLAIMER OF HEALTH CARE RELATED SERVICES

The Counselor encourages the Client to continue to visit and to be treated by his/her healthcare professionals, including, without limitation, a physician. The Client understands that the Counselor is not acting in the capacity of a doctor, licensed dietician-nutritionist, psychologist or other licensed or registered professional. Accordingly, the client understands that the Counselor is not providing health care, medical or nutrition therapy services and will not diagnose, treat or cure in any manner whatsoever any disease, condition or other physical or mental ailment of the human body.

The Client has chosen to work with the Counselor and understands that the information received should not be seen as medical or nursing advice and is certainly not meant to take the place of your seeing licensed health professionals.

PERSONAL RESPONSIBILITY AND RELEASE OF HEALTH CARE RELATED CLAIMS

The Client acknowledges that the Client takes full responsibility for the Client's life and well-being, as well as the lives and well-being of the Client's family and children (where applicable), and all decisions made during and after this program.

The Client expressly assumes the risks of the Program, whether or not such risks were created or exacerbated by the Counselor. The Client releases the Counselor, his/her heirs, executors, administrators

and assigns, its officers, directors, shareholders, employees, teachers, lecturers, agents, health counselors and staff (collectively, the Releases) from any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands whatsoever, in law, admiralty or equity, which against the Release's, the Client **ever had, now has or will have in the future against the Release's, arising from the Client's past or future participation in, or otherwise with respect to, the Program, unless arising from the gross negligence of the Releases'.**

CONFIDENTIALITY

The client acknowledges the counselor will keep all information exchanged during the program sessions in strict confidentiality. Additionally, the client is aware that the counselor is prohibited from disclosing protected healthcare information, except upon written authorization by the client.

CHOICE OF LAW, ARBITRATION AND LIMITED REMEDIES

This agreement shall be construed according to the laws of the State of New Jersey. In the event that any provision of this Agreement is deemed unenforceable, the remaining portions of the Agreement shall be severed and remain in full force. In the event a dispute arises between the parties, either arising from this Agreement or otherwise pertaining to the relationship between the parties, the parties will submit to binding arbitration before the American Arbitration Association (Commercial Arbitration and Mediation Center for the Americas Mediation and Arbitration Rules). Any judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall be conducted by a single arbitrator. The sole remedy that can be awarded to the Client in the event that an award is granted in arbitration is refund of the Program Fee. Without limiting the generality of the foregoing, no award of consequential or other damages, unless specifically set forth herein, may be granted to the Client.

If the terms of this Agreement are acceptable, please sign the acceptance below. By doing so, the Client acknowledges that: (1)he/she has received a copy of this letter agreement; (2)he/she has had an opportunity to discuss the contents with the Counselor and, if desired, to have it reviewed by an attorney; and (3) the client understands, accepts and agrees to abide by the terms hereof.

*****Cancelation Policy***** 24 hour calendar day notice or full payment is expected.

Modality or Modalities chosen_____

Signature of client: _____Date: _____

Signature of Practitioner: _____Date: _____