

Consent and Release of Liability

PATIENT INFORMATION

DATE: _____

FIRST NAME: _____

LAST NAME: _____

COMPANY: _____

PHONE: _____

EMAIL: _____

ADDRESS

ADDRESS: _____

CITY: _____

STATE: _____

ZIP CODE: _____

CONTRAINDICATIONS OR CAUTIONS YES/NO

Cardiac pacemakers or other electronically powered implants	<input type="radio"/>	<input type="radio"/>
Pregnant	<input type="radio"/>	<input type="radio"/>
Cardiac Fibrillation	<input type="radio"/>	<input type="radio"/>
Recently Consumed:		
Drugs or Alcohol	<input type="radio"/>	<input type="radio"/>
Sensitivity to Electrical Current	<input type="radio"/>	<input type="radio"/>
Lack of Sensation of Skin	<input type="radio"/>	<input type="radio"/>
Phlebitis or Thrombophlebitis	<input type="radio"/>	<input type="radio"/>
High or Low Blood Pressure	<input type="radio"/>	<input type="radio"/>
High or Low Blood Sugar	<input type="radio"/>	<input type="radio"/>
Severe Mental Disorder	<input type="radio"/>	<input type="radio"/>
Epileptic Tendencies	<input type="radio"/>	<input type="radio"/>
Menstruating Uterus	<input type="radio"/>	<input type="radio"/>
Organ Transplants	<input type="radio"/>	<input type="radio"/>
Cancerous Lesions	<input type="radio"/>	<input type="radio"/>
History of Fainting	<input type="radio"/>	<input type="radio"/>
History of Strokes	<input type="radio"/>	<input type="radio"/>
Botox Treatments	<input type="radio"/>	<input type="radio"/>
Recent surgery	<input type="radio"/>	<input type="radio"/>
Open Wounds	<input type="radio"/>	<input type="radio"/>

Medications

Scars & Locations

Major Complaints?:

Waiver Of Liability

I understand the Avazzia devices imparts electrical frequencies into the body. I have truthfully answered the above list of contra-indications for this therapy. Avazzia or QRS does not prescribe medical treatments or diagnoses. It is recommended that I see a physician for any physical ailment that I may have. I have stated all my known medical limitations. In consideration of the treatment offered to me, I agree that I will not institute any suit or claim against Avazzia, First Alternatives, their representatives, or practitioners for any damage, loss or injury to either person or property. I am in good health and have no physical limitations, which should affect my safe use of the devices. I am at least 18 years of age and otherwise legally competent to sign this agreement, This release shall be effective and binding upon my assigned and me.

Patient Signature

Date: _____

Printed Name: _____

Practitioner Disclosure

I have in trust & faith advised the patient and recognize that the patient has been forthcoming with any questions I may have asked regarding any possible conditions that I may have foreseen within the wisdom of my practice:

Practitioner Initials : _____