



**PROACTIVE WELLNESS OF THE ROCKIES  
(the "Center")**

**RELEASE, WAIVER, AND HOLD HARMLESS AGREEMENT  
(the "Agreement")**

**IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED THERAPY OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED THERAPY OR OTHER POSSIBLE TREATMENTS, CONSULT YOUR PHYSICIAN BEFORE SIGNING THIS RELEASE WAIVER AND HOLD HARMLESS AGREEMENT AND COMMENCING THERAPY.**

*By signing in the space provided below, you authorize the Center to provide one or more of the following therapies or services (the "Therapy" or "Therapies") as agreed upon by Client and the Center, subject to the terms and conditions stated herein as well as the policies and procedures of the Center: 1. Holistic Pediatric Consulting; 2. Brainwave Optimization; 3. Hyperbaric Oxygen Therapy; 4. Crossinology Brain Integration Technique; 5. ABA Therapy; 6. Holistic Health Coaching; 7. FAR Infrared Sauna; 8. Ionic Foot Baths; 9. Avalon LED Light Therapy; 10. Biomat; 11. The Human Joint.*

The undersigned Client, or Parent(s)/Legal Guardian(s) of Client (collectively "Client"), agrees to the following terms and conditions:

1. Assumption of Risk and Waiver: I have informed myself of the policies, procedures and methods employed by the Center, and consent to the use thereof in providing therapies or services to Client. I hereby acknowledge that I have voluntarily chosen the Therapies for Client and understand the risks involved in the Therapy. I recognize that the Therapies may involve risk of injury and I agree to accept any and all associated risks, including, but not limited to, minor bodily injury, severe bodily injury, and death. I acknowledge that it is my responsibility to inform Client's physician of Client's Therapy.
2. Health History: I understand and agree that Center takes reasonable steps to maintain the safety and well-being of its clients. I confirm that I have disclosed all medical conditions of Client that may be affected in any way by the Therapy. I acknowledge that I am responsible for updating this release if the medical condition of Client changes.
3. Release and Hold Harmless: I agree to release and hold the Center, its respective heirs, directors, members, subsidiaries, affiliates, agents, officers, assigns, volunteers, employees, independent contractors, and affiliated groups, harmless for any illness, injury, death, personal and/or property damage, property theft, or other loss incurred. I agree to indemnify, defend and hold harmless, to the fullest extent permitted by law, the Center, its managers, members, employees, agents, volunteers and assigns from and against all claims arising out of or resulting from the Therapies received by Client. "Claim" as used herein means any financial loss, claim, suit, action, damage, or expense, including but not limited to attorney's fees, attributable to bodily injury, sickness, disease or death. I further understand that this Agreement is intended to be as broad and inclusive as permitted by the laws of

the State of Colorado and that if any portion hereof is held invalid, I agree that the balance shall, notwithstanding, continue in full legal force and effect.

4. No Guarantee: I understand that much of the success of the Therapy will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I further understand that Center makes no representations or warranties on the results that may be obtained through the Therapy. As a result, I agree not to pursue a claim against the Center if I am dissatisfied with the results of the Therapy.
5. Governing Law: This Agreement shall be construed and enforced in accordance with the laws of the State of Colorado. All disputes relating to the interpretation and enforcement of the provisions of this Agreement shall be resolved exclusively by the appropriate courts located in Denver, Colorado.
6. Client Certification: I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my primary physician regarding risks associated with the Therapies.

Dated: \_\_\_\_\_ Signature: \_\_\_\_\_

Client signing on his/her own behalf **or** as Parent(s)/Legal  
Guardian(s) if Patient under 18 years old

X \_\_\_\_\_  
Printed Client Name

X \_\_\_\_\_  
Printed Parent(s)/Legal Guardian(s) Name

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_