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INFORMED CONSENT FOR VIRTUAL ENERGY OPTIMIZATION THERAPY

What is a Virtual Energy Optimization Therapy?

Our **virtual Energy Optimization** sessions offer a unique, non-invasive way to assess and support your body's energy balance, even from the comfort of your home. Using advanced technology, these remote sessions can help you address a range of concerns, such as stress, fatigue, mental clarity, and physical well-being.

How Our Virtual Sessions Work

Our virtual Energy Optimization sessions are conducted via a secure Zoom meeting. During the session, we connect face-to-face in real-time, guiding you through the process while the device works remotely to assess your body's energetic responses.

What to expect from an Energy Optimization session?

Our virtual system works on the energetic level, meaning physical proximity is not necessary for conducting the session effectively. Through this technology, we can measure and correct subtle imbalances in your body's energy fields, supporting relaxation, clarity, and wellness—no matter where you are.

Energy Optimization therapy is non-invasive. It is important to notify the practitioner if your medical history changes such as becoming pregnant or if you have been diagnosed with an unexpected medical condition.

Please check or circle one of the multiple options in a line if you have or have had any of the following:

ACNE / ECZEMA / PSORIASIS / DRY SKIN	DIFFICULTY SWALLOWING	INFERTILITY / MISCARRIAGE
ALLERGIES	ENDOMETRIOSIS	KIDNEY PROBLEMS
ARTHRITIS	EMPHYSEMA	LIVER PROBLEMS
ATHEROSCLEROSIS	EPILEPSY	LOW IMMUNE SYSTEM =>FREQUENT INFECTIONS
ASTMA	ELEVATED CHOLESTEROL	MEMORY IMPAIRMENT / INABILITY TO CONCENTRATE
BIRTH DEFECTS	EYELID SWELLING (PUFFY EYES)	MOOD CHANGES / IRRITABILITY
BRITTLE NAILS	ENDOCRINE PROBLEMS	MIGRAINES / HEADACHES
BRONCHITIS	FLUID RETENTION	MONONUCLEOSIS / OTHER CHRONIC INFECTIONS
CANCER	GLAUCOMA / CATARACT	MUSCLE LOSS / MUSCLE WEAKNESS / MUSCLE CRAMPS
CHRONIC FATIGUE / FATIGUE / APATHY	GOUT	(PRE)MENSTRUAL PROBLEMS PAIN / IRREGULAR / FLOW CONCERN
CONSTIPATION	HAIRLOSS	OSTEOPOROSIS
COLD INTOLERANCE COLD HANDS AND FEET	HOARSENESS	THROAT PAIN
CYSTIC BREASTS	HERNIA	STROKE
CYSTIC OVARIES	HERNIATED DISK	UNDERWEIGHT / OVERWHEIGHT
DEPRESSION / ANXIETY / NERVOUSNESS	HYPOTENSION / HYPERTENSION	OTHER:
DIABETES		

Family History: Please indicate if any family members have had any of the following medical problems and if so who:

DIABETES	HEART DISEASE	ALCOHOL PROBLEMS
HYPERTENSION	HEPATITIS / LIVER DISEASE	MENTAL / EMOTIONAL PROBLEMS
STROKE	CANCER	OTHER:

Describe and rate 1-10 any health concerns and your objectives in seeking wellness services here:

CONFIDENTIALITY

Client information will be kept in confidence and will not be disclosed to anyone without your written consent.

CONSENT

I understand that the attending practitioner, Adriana Costin, is not a licensed doctor and does not portray herself as one, but is providing Energy Optimization training services. I understand that the service provided identifies energetic imbalances and the procedure utilized is stress reduction. I fully understand that the attending practitioner, Adriana Costin, does not offer allopathic drugs, surgery, chemical stimulants or any other conventional treatments. In addition, Adriana Costin does not diagnose, treat or otherwise prescribe for my disease, conditions or illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited this service 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 Energy Optimization measurements and 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.

Client's Signature

Client's Name

Date

Phone #

E-mail address

FOR PARENTS/GUARDIANS OF MINOR CLIENT

I attest that I have full legal authority to make decisions for the minor named below, and that I give my permission for him/her to undergo Energy Optimization training.

Parent/Guardian's Signature

Minor's Name

Date