Consent, Disclosure and Disclaimer Form

OnPoint Health and Wellness LLC

I request and give permission to Jennifer Kaye Nichols, CBP, ACI to proceed with and set up a personal care plan with self-help care, for the purpose of improving my well-being.

I understand that Jennifer Kaye Nichols, CBP, ACI has a certification in Biofeedback and Auricular Therapy from the Institute of Bio-energetic Medicine (IBEM) of Colorado, and is required to maintain continual education (CE) as qualification to continue with her certifications.

I understand that any care received, be it Bio-energetics, Auricular Therapy, Frequency Care, Meditation Therapy, or any other under direction of Jennifer Kaye Nichols, CBP, ACI is not intended or used as diagnosis, treatment, prescription or cure for any condition, mental or physical, real or imaginary, and that it is not a substitute for regular medical care. My goal is to strengthen the body's ability to regain the balance of both the body and the mind. Although everything possible is done to ensure a plausible outcome, each patient responds differently to care. Your progress in care is based on many factors, including your commitment to making lifestyle changes, acquiescence to sound suggestions, and adherence to the care plan. By embarking on biofeedback alternative health care, you agree that OnPoint Health and Wellness, LLC is not fully responsible for the success or failure of the outcome. Let's work together to get to the root of the symptoms you are managing.

By signing, I acknowledge that OnPoint Health and Wellness, LLC has active video surveillance. One is located in the front waiting room and one is located in the main room along with the children's quiet play area, the Bio-metrics scanning equipment, and sensitive personal filing system.

This signature is an acknowledgement that you have received, read, and understand this notice of the Consent, Disclosure and Disclaimer Form and are giving permission to proceed with your personal health care needs.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Name of Legal Guardian, if applicable