



Consent form

Permission to attend Health Mentorship sessions at Reignite Health PTY (LTD)

I, Full Name: _____, understand and declare that

- I approached Reignite Health PTY (LTD) to attend Health Mentorship sessions at my own will
- Sessions will happen weekly, and payment is to be made prior to the sessions for that month
Receipt of proof of payment by Reignite Health PTY (LTD) secures my sessions for the month ahead (i.e. 4 (four) sessions)
- I am aware that the advice and knowledge given in the Health Mentorship sessions are for informational and educational purposes only. If I have any concerns about any signs or symptoms I may be experiencing that are similar to what is discussed, I will seek medical professional advice for a formal diagnosis
- I am different to other individuals, therefore the methods of prevention and management discussed may not work best for me.
- Reignite Health PTY (LTD) does not take responsibility for any liability or damages for the knowledge shared in the sessions; and I will not cause any harm to Reignite Health PTY (LTD) for any medical diagnosis I have prior and/or post to the Health Mentorship sessions
- Any injury to myself/dependent/property, or death, (prior and/or post to the Health Mentorship sessions) will not be Reignite Health PTY (LTD)'s fault
- I confirm that I am an adult and of sound mind to consent to attending Health Mentorship sessions for myself/the dependent
- I am aware that Reignite Health PTY (LTD) will not disclose my personal reasons for attending Health Mentorship sessions with anyone, without my consent

I hereby agree that I understand the above and that I was not forced to consent to Health Mentorship sessions. I also agree that all questions regarding the consent form have been answered/clarified.

Signature (parent/guardian if patient is under 12)

Date

Reignite health authorised signatory

Date