Joyful Vibes VAT
TUNE INTO BETTER WELL-BEING

NEW CLIENT INFO AND WAIVER

Name _____ Date of Birth _____

Address _____

Phone _____

Email _____

Preferred Method of Contact:
◯ text ◯ call ◯ email

Emergency Contact _____

Relationship _____

Phone _____

Reason(s) for visit:

I understand that vibroacoustic therapy (VAT): is a relatively new therapy that may help to relieve pain, calm the nervous system, and relax and regulate the mind; every person's response to VAT is unique; in rare instances, some individuals may temporarily experience negative feelings or memories or uncomfortable physical sensations; there is no guarantee, expressed or implied, that this therapy will cure any condition or disease.

I also understand that if I have very low blood pressure, an active bleeding disorder or thrombus, a pacemaker, am or could be in the first trimester of pregnancy, have had a psychotic episode or have post-traumatic stress disorder, there could be a slight risk for an adverse reaction from VAT. I have a physician's approval and have discussed my history of any of the aforementioned disorders with the vibroacoustic therapist prior to receiving treatment.

INFORMED CONSENT. I hereby certify and accept the following: (initial where applicable)

_____ ☐ Physical Condition. I am of adequate physical condition to undergo VAT despite any current medical conditions I may possess.

_____ ☐ Assumption of Risk. I assume the risk of physical injury from any advice, instruction or action conducted during or as a result of a VAT session.

_____ ☐ Reporting Discomfort. I will immediately alert the vibroacoustic therapist if I experience any discomfort, distress or uncomfortable feelings.

_____ ☐ Indemnification. I will NOT hold the vibroacoustic therapist or their employer, affiliates, agents or any other entity or individual connected to them (directly or indirectly), liable for any result from VAT sessions.

_____ ☐ Responsibility. I assume all responsibility for my participation in the VAT sessions.

I hereby consent to and authorize treatment by (therapist name) ___JODI E. CHRISTMAN_____

Signature _____ Date _____