

EMPOWERING WORKSHOPS 4 U

Re-connect to your inner-self and set your spirit free

Professional Disclosure Form and Release

I, _____ understand that the Crystal Light Bed Therapy session I receive is provided for the basic purpose of relaxation and chakras balancing.

I will also let the Crystal Light Bed operator know if I need the temperature adjusted, the music changed, or the lights dimmed.

I further understand that Crystal Light Bed Therapy session should not be used as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

I am aware that the Crystal Bed Therapy is working by flickering and flashing light and color, and I have no obligation using this kind of treatment.

By signing this form, I hereby release Crystal Light Bed Therapy owner, operators from any and all liability for future injuries or illnesses due to my participating session.

I have read, understand, and agree to the content of this Professional Disclosure Form and Release.

First name: _____

Last name: _____

*Child's name: _____

E-mail address:

Signature: _____

Date: _____

*Guardians/parents must provide filled and signed form, for a minor/child who participates a Crystal Light Bed session.