Bio Therapy DDS Informed Consent Form

Please initial that you understand each section

___ I understand that the DDS therapy given to me, is for the purpose of stress reduction, pain reduction, relief from muscle tension, and/or increasing circulation.

___I understand that the therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of the therapy.

___I understand that this therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

___The following conditions may prevent you from utilizing this therapy, update your therapist.

Please circle any medical conditions you may have:

- Thrombosis
- Phlebitis
- Hypertension higher than 160/110 mmHg
- High Anxiety meds
- Lung/Kidney Failure
- Acute infectious Diseases
- Osteoporosis
- Angina
- Pacemakers
- Epilepsy
- Pinched Nerves
- Fracture
- Metal/Silicone implants
- Pregnancy
- Menstruation
- Hemorrhagic disease
- Psoriasis/Eczema
- High Blood Pressure
- Cancer
- Heart problems/failure
- Nervous/Psychotic Conditions
- Diabetes
- Malignancy
- Other Serious Condition

By signing this release form, I waive and release my therapist and DDS Bio Therapy from any and all liability relating to this session.

Print Name: _____ Signature: _____ Date: _____