Blooming 4 Wellness LLC

Adult/Child informed consent for use of intention Based Field Resonance Testing ("IBFRT"), Whisperology and Cold Laser Therapy

PLEASE READ CAREFULLY BEFORE SIGNING

I, understand, herby consent to an Intention Based Field Resonance Testing ("IBFRT") consultations (hereinafter "treatment") for myself and or my child, or the person named below for which I am legally responsible.

I specifically authorize Ashlin Tulip to conduct IBFT, Whisperology, Cold Laser Therapy, to develop a protocol, and to prepare numerical sequences, vials, and/or compatibility with supplements, food, etc. I acknowledge that none of these are intended for the treatment, diagnosis, or cure of any disease.

I hereby consent that Ashlin Tulip has provided me with specific, complete and accurate information regarding the proposed treatment and services, including, but not limited to:

-The nature and purpose of the treatment
-The benefits of the treatment
-The expected treatment side effects or risks of side effects, if any, which are reasonable possibility
-Alternative treatment modes and services
-The probable consequences of not receiving the proposed treatment and services
- The time period for which the informed consent is effective; which shall begin upon signing and continue for 24 months, unless withdrawn earlier
-The right to withdraw informed consent at any time, in writing
- The liability, if any, that I or any of my relatives may have for the cost of my care and treatment and the right to receive information about charges for care and treatment services.

I understand that IBFRT, Whisperology, Cold Laser Therapy is a non-invasive gentle method of assessment for potential imbalances that may contribute to various dysfunctions within the body.

I understand that IBFRT, Whisperology, Cold Laser Therapy does not purport to substitute or replace the advice I receive from my medical provider. If I need medical care for any reason, I should obtain the advice of my provider. Any recommendations I choose to follow regarding IBFRT, Whisperology, Cold Laser Therapy testing, protocols are because I wish to have a holistic approach to my care.

I acknowledge that I am not currently pregnant, trying to become pregnant or breastfeeding. Should this condition change, I will notify Ashlin Tulip prior to any IBFRT, Whisperology, Cold Laser Therapy testing.

I consent that I have been notified of my rights orally and given the option of a copy of the Client Bill of Rights, and I have been given the opportunity to ask any questions about my care and treatment.

I affirm that no promise of guarantee has been made regarding the results of IBFRT, Whisperology, Cold Laser Therapy. I intend this informed consent form to cover the entire course of that IBFRT, Whisperology, Cold Laser Therapy, consultations, protocols, vial(s) and numerical sequence (s), compatibility with supplements, food, etc. for my present condition and/or for any further conditions.

I understand the information above and guarantee all intake forms have been completed and correctly and to the best of my knowledge. I further understand it is my responsibility to inform Ashlin Tulip or any subsequent changes in my symptoms or health at any time.

I have read and understood the above statements regarding IBFRT, Whisperology, Cold Laser Therapy consultations, testing, protocols, and drops. I have decided that it is in my best interest to proceed with IBFRT, Whisperology, Cold Laser Therapy as a complementary approach to my care. By signing below, I consent to said treatment.

PATIENT IS A MINOR (UNDER AGE 18), PARENT OR GUARDIAN MUST COMPLETE THE BELOW:

_____ _____

PATIENT OR MINOR'S FULL LEGAL NAME DATE OF BIRTH

_____

SIGNATURE OF PARENT/GUARDIAN/ PATIENT

_____

PRINT PARENT/GUARDIAN/PATIENT

_____

ADDRESS OF PATIENT STATE ZIP

_____

ADDRESS OF PARENT/GUARDIAN STATE ZIP

(_____) _____-_____ _____

CELL OR HOME PHONE (CIRCLE) E-MAIL ADDRESS

EMERGENCY CONTACT INFORMATION

NAME RELATIONSHIP PHONE

ADDRESS STATE ZIP

PERMISSION TO SHARE ALL INFORMATION WITH FOLLOWING PERSON(S):

FULL LEGAL NAME RELATIONSHIP PHONE

FULL LEGAL NAME RELATIONSHIP PHONE

AUTHORIZATION SIGNATURE