Calmglow
FUNCTIONAL MEDICINE

209-247-9170
calmglow.com

Consent for Therapy:

I request and consent to the administration of Calmglow therapies and authorize prescriptions by the Calmglow health providers. I acknowledge that there are no guarantees or assurances made with respect to the benefits of these therapies prescribed to me. I agree to comply with requests for ongoing follow up to assure proper monitoring of my levels when recommended. I understand that I will be responsible for administering these therapies prescribed to me. I will conform and comply with the recommended doses and methods of administration. I agree to report any adverse reaction to problems that might be related to my therapies. I understand that the role of the Calmglow providers are for Functional Medicine, Nutritional and Health Coaching therapies, only. I agree that I am and will be under the care of another physician for all other medial concerns. I have been informed that insurance companies may not pay for my therapy testing and supplements. I therefore agree to pay for all services, including laboratory and pharmacy charges myself, with the understanding that I may not be reimbursed by my insurance company. I have read this consent and understand its' contents. I fully understand what I am signing and herby request and consent to treatment.

Testimonial Waiver and Release:

Calmglow Inc desires to use and publicize the name, likeness, and other personal characteristics and private information of the individual named below ("I" or "me") for use as a testimonial for it's product named Calmglow as part of its advertising, promotion, other commercial and business purposes. In exchange for the intangible value I gained and will gain from the Product and by participating in Company's publicity programs and other good and valuable consideration, the receipt and sufficiency of which I hereby acknowledge, I give Company my permission for such use and publicity for such purposes. I hereby irrevocably permit, authorize, grant, and license Company and it affiliates, successors, and assigns, and the employees, officer, directors, and agents of each and all of them the rights of display exhibit, transmit, broadcast, reproduce, record, photograph, digitize, modify, alter, edit, adapt, create derivative works, exploit, sell, rent, license, otherwise
use, and permit others to use my name, image, image, likeness, appearance, voice, professional and personal biographical information as part of a testimonial for the Product.

I represent and warrant to Company that I am at least eighteen (18) years of age, and I have full right, power, and authority to enter into this Agreement and grant the rights hereunder.
Signed :_____
Printed:_____ Date:_____
Testimonial Waiver and Release: () opt out

HIPPA Acknowledgement Form:

(Print Name)_____ understand that as a condition to receiving treatment, my "Provider" may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this practice. I also understand that I have a right to request the "Provider" to restrict how my health information is used or disclosed. The "Provider" does not have to agree to my request for the restrictions, but if he/she does agree, the "Provider" is bound to abide by the restrictions as agreed. Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that the "Provider" has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent. You may disclose information to the following:

Name/Relationship to Patient/ Phone Number_____
Name/Relationship to Patient /PhoneNumber_____