5 POINTS MASSAGE

Ear Candling Liability

Name | Phone ( ) | DOB

Address | City | State | Zip

E-mail | Referred by:

In Case of Emergency: | Relation | Phone ( )

Occupation: | Physician:

☐ Male ☐ Female

By signing this release, I am stating that I understand the possible risks involved with an ear candling treatment and do hereby waive my right to hold 5 Points Wellness or any of its employees accountable for any injuries directly caused by this treatment.

I further comply to follow all directions given to me by the practitioner understanding that should I not follow these directions I could cause injury to myself and/ or the practitioner.

I also acknowledge that 5 Points Wellness has the right to refuse treatment should I show any signs of a condition that is contraindicated for ear candling.

Print Name _____ Date _____

Signature _____

Consent to Treatment of a Minor: By my signature below, I hereby authorize the employees of 5 Points Wellness dba 5 Points Massage to administer massage, bodywork, homeopathic, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent of Guardian _____ Date _____