Client Acknowledgement of Risk & Release of Liability

TO: Jenna Bishop, R. BIE, CNP ("Practitioner")

RE: Wellness Services

The undersigned _____ hereby acknowledges and agrees as follows:

1. Nutritional Counselling Services. The purpose of nutritional counselling is to improve the overall health, vitality and well-being of the body through nutritional education and the use of natural food and non-medicinal nutritional supplements.
2. BIE Services. The purpose of Bioenergetic Intolerance Elimination (BIE) is to direct energy directly onto various acupuncture points on the body to restore physiological balance within the body.
3. Important Information about the Wellness Services: The Wellness Services include nutritional counseling and the BIE services used either alone, or in combination. I acknowledge:
   - € The Practitioner is not a licensed medical doctor, naturopath or dietitian (each a "Licensed Health Professional").
   - € I will inform the Practitioner as accurately and honestly as possible of all of my pre-existing health conditions (including without limitation if I am pregnant, nursing, develop an acute illness (eg. common cold, flu, etc.), have a heart condition or a pacemaker) and of my health and wellness concerns including relating to my physical habits, medical history, moods, energy levels, likes and dislikes, lifestyle and diet ("Background Information").
   - € In providing the Wellness Services to me, the Practitioner is relying upon the truth, accuracy and completeness of the Background Information I provide.
   - € If I am consulting the Practitioner with respect to a medical condition, the Wellness Services are intended to supplement treatments provided by Licensed Health Professionals and I am not to alter or discontinue such treatments without consulting the individual who prescribed the treatment. If I have not previously consulted a Licensed Health Professional about a known or suspected medical condition, I acknowledge that I am directed to immediately do so.
   - € BIE therapy and use of the GSR-120 unit requires touching the outer surface of the dermis at various acupuncture points with a probe and/or light pen, and/or the practitioner's hand. I consent to such touching and acknowledge it is my responsibility to

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immediately notify the Practitioner of any discomfort I experience, or if I wish at any point to stop the procedure.

- € BIE therapy and the GSR-120 unit is not a cure for anaphylactic, life threatening or non life threatening allergies, medical conditions or diseases such as Lyme Disease. I am directed not to, for any reason, whether before or after the provision of the Wellness Services, to ingest or expose myself to any substance that I have been diagnosed as allergic or anaphylactic or that I suspect may have an allergy unless I have first been given consent by a qualified Licensed Health Professional.
- € All suggestions regarding the use of herbs or nutritional supplements are based on historical and traditional use.
- € The Background Information and any notes and records prepared by the Practitioner will be kept on file in accordance with the law. I authorise the Practitioner to discuss my case on a confidentially basis with my physician or naturopath, or other qualified health practitioners within the context of my personal plan.
- € Throughout the course of my personal plan I will inform the Practitioner of all changes to my health status and medications, including without limitation, if I become pregnant, am nursing, develop an acute illness (eg. common cold, flu, etc.), or develop a heart condition.
- € If the Practitioner suspects the existence of a medical condition I will be informed of this suspicion. However, I acknowledge this is not a diagnosis or conclusion about the state of my health and that I am directed to promptly consult an appropriate Licensed Health Professional about any suspected medical conditions.
- € The Practitioner will recommend a personal plan and will inform me of expected benefits, potential risks, side effects, financial costs, likely consequences of not following the plan, and possible alternative course(s) of action that are available. I understand that results vary from person to person, are not guaranteed, and realize that not all risks and complications can be anticipated. I understand that, upon my own free will, I can withdraw my consent at any time and discontinue a personal plan.

4. Cancellation Policy. Your appointment time is reserved just for you. 24 hours notice is required for any cancellations or changes to your appointment. Clients who provide less than 24 hours notice, or miss their appointment, may be charged a cancellation fee of 50% of the appointment cost. Cancellation fees will not be enforced for late cancellations for acceptable or unforeseen reasons, such as personal or family emergencies.

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ASSUMPTION OF RISK AND RELEASE OF LIABILITY.

I hereby accept all risk to my health that may result from my participation in the Wellness Services provided by the Practitioner Jenna Bishop, and I hereby release Jenna Bishop, on my behalf and on behalf of my personal representatives, estate, heirs, next of kin and assigns from any and all costs, claims, causes of action and damages arising from any and all illness or injury to my person, including my death, that may result from or occur as a result of my participation in the Wellness Services, whether caused by negligence or otherwise.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A FULL AND FINAL RELEASE OF ALL COSTS, CLAIMS, CAUSES OF ACTION AND DAMAGES OF ANY KIND ARISING FROM OR IN CONNECTION WITH THE WELLNESS SERVICES.

FULL NAME: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

DAYTIME PHONE NUMBER: _____

EVENING PHONE NUMBER: _____

EMAIL: _____

CLIENT SIGNATURE: _____ DATE: _____

Initial: _____