THE Salt Room
INHALE • EXHALE • STAY WELL

ADULT
Client Information Sheet And Disclosure

Client's Name *(Last, First)*: _____ D.O.B. _____/____/_____

Address: _____ State: _____ Zip Code: _____

City: _____ Cell Phone: _____

Email: _____

Reason for your visit: _____

Goals for visit: _____

How did you hear about us? Check all that apply. Google_____ Facebook _____ Signage_____

Print Advertisement _____ (where?) _____ Another Client (name) _____

Doctor _____ (name)_____ Other _____

I, the above-named client, have requested and agreed to undergo the process of Salt therapy. I have been informed about the potential benefits, risks and consequences of Salt therapy. All my questions pertaining to Salt therapy have been answered to my satisfaction. I am satisfied with and understand the information provided as well as I acknowledge that THE SALT ROOM recommends that all medical conditions should be treated by a physician competent in treating that condition. I further acknowledge that THE SALT ROOM takes no responsibility for clients choosing to treat themselves by means of Salt therapy, which has not been evaluated by the Food and Drug Administration and is not intended to diagnose, treat, cure or prevent any disease. I understand that for all my health concerns, it is my responsibility to consult an appropriately licensed healthcare practitioner. I further release THE SALT ROOM VALRICO from any legal ramifications should an injury, death, or illness occur as a result of Salt therapy.

I hereby give my consent to participate in the Salt Therapy Sessions entirely at my own risk.

Signature: _____

Date: _____ Staff: _____

Initial: _____ **I have read, understand, and will comply with the "Salt Room Etiquette" provided to me.**

The Salt Room Valrico
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