Waiver and Release | Informed Consent Form

I, _____ (the "undersigned"), hereby consent to an Advanced Allergy Therapeutics (AAT) treatment at [Clinic name and address]

I understand that such procedures are non-invasive.
The clinic and all its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms and that the clinic cannot guarantee any results in the reduction of symptoms. The clinic cannot guarantee that new reactions will not develop in the future. While the treatment can address many symptoms associated with allergies and sensitivities, some cases do not respond to treatment.

I also understand that a risk factor for treating the symptoms associated with allergies and sensitivities is the possibility of increased sensitivity. This can happen with traditional immunotherapy treatments as well. I assume all responsibility for unpredictable reactions which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention.

I understand that the clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies, allergies resulting in anaphylaxis or any allergies that I have been prescribed an epi-pen.

_____ No, I do not have any life-threatening allergies and do not carry an epi-pen

_____ Yes, I have the following allergies that may cause anaphylaxis

_____

I agree to pay the clinic the standard fee for all treatments administered and any cancelation fees when required.

In witness thereof, the undersigned executed the Agreement as of Date: _____

_____

Signature of Undersigned

_____

Signature of Parent or Legal Guardian

_____

Signature of Practitioner