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BREEZE HOLISTICS Health Disclaimer

Client Information

Name:

Please read carefully and only sign if you are in full agreement with its contents

I ----- confirm that I have understood the treatment that I am to receive and confirm that I am willing to proceed without confirmation from my own GP or Consultant.

Or

I ----- confirm that I have understood the treatment and given my medical history I would prefer to consult with my GP or Consultant prior to receiving the treatment.

Medical Professional Signature.....Date

Name:

Surgery Stamp



You should note that if the therapist is unable to explain to you the contra indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your GP or Consultant.

It is your responsibility and not that of the Therapist to consult your GP or Consultant.

I hereby indemnify the Therapist against any adverse reaction sustained as a result of the treatment

Client Signature.....

Date.....

Therapist Signature.....

Date.....