Auricular Therapy Consent Form

I, (named below) _____, hereby request and consent to auricular therapy within the scope of practice for myself by LaVelle Johnson.

Before signing this form, please read the following:

I understand that auricular therapy is a generally safe method of treatment that involves the insertion of ear seeds in the auricular region. I acknowledge that it may occasionally have some side effects including bruising, numbness, tingling or pain near the ear seeds lasting several days, as well as dizziness or fainting. Unusual risks of acupressure include spontaneous miscarriage and nerve damage. Emotional release and regression to past traumatic events may also result from any or all aspects of treatment.

I understand that while the list above describes major risks of treatment, other side effects and risks may occur that are not listed.

I intend this consent and release form to cover this and any future events that I participate in for auricular therapy.

As with any health-related treatment, I understand that it is impossible to accurately predict how any one person may respond to treatment and I acknowledge that there may be other effects not listed on this consent form.

I understand that auricular therapy is not a replacement for diagnostic medical procedures. This healing session is not intended to treat or diagnose a condition.

I confirm that I have read and understand the above, that I have been told about risks and benefits of auricular therapy, and that I have had an opportunity to ask questions.

I hereby agree to indemnify and hold harmless LaVelle Johnson, L. Zen Skincare and Health Studio LLC, from any loss, liability, damage, judgement awards or costs, including court costs and attorneys' fees that may be incurred due to my participation in said therapy or subrogation suits or claims, whether caused by the negligence of Releasees or otherwise.

I have carefully read this form and fully understand its contents. All information I have provided in any and all intake forms is true. I am aware this is a release of liability, a waiver of claims, an agreement not to sue, an indemnity, and a contract between myself and the Releasees described herein.

By signing below, I willfully agree to the above and consent to participate in auricular therapy.

Signature _____ Date_____

(Please print your full legal name here: _____)