Renewed
HEALTH & WELLNESS

PEMF & OmniBrain Wave System WAIVER

Please Print Name: _____ Date: _____
Address: _____City_____
Province: _____ Postal Code _____
Phone #: _____ Date of Birth _____M/D/YEAR

Email: _____

Renewed Health & Wellness advises the client to NOT receive a PEMF (Pulsed Electromagnetic Frequency) session if you have any of the conditions listed below. **(Circle YES or NO)**
Magnetic resonance stimulation does not replace medical therapy. Always consult your doctor first about any unfamiliar complaints.

- YES/NO. Pregnancy
- YES/NO. Epilepsy
- YES/NO Electronic implants such as pace makers or insulin pumps
- YES/NO Photosensitivity
- YES/NO Intoxication
- YES/NO. Presence of tumors
- YES/NO. Serious cardiac arrhythmia
- YES/NO. Acute attacks of hyperthyroidism
- YES/NO. Extreme sensitivity to electromagnetic waves

SIDE EFFECTS

In therapeutic treatment of chronic cases, a so-called initial worsening (healing reaction) arises in approximately 10% of the patients treated in the first few hours or days of application, such as through an increase in the symptoms. Light pain may be a consequence in problem areas due to the activation of the circulatory system

By signing below I confirm that the answers to the questionnaire are true and correct. I have read the contents of this Waiver Form carefully and state I am not aware of any medical conditions or any other reason that would prohibit me from receiving PEMF (Pulsed Electromagnetic Frequency) sessions. I understand individual results may very. I am using this PEMF mat and the OmniBrain and I hereby give my consent to release the owners, operators, and manufacturer from any damages that I might incur due to the use of this Therapy.

Client Name (Please Print): _____
Client Signature: _____
Date ____/____/____