First Alternatives

Waiver & Photo Release

PATIENT INFORMATION

DATE: ______________________________

FIRST NAME: ________________________

LAST NAME: ________________________

COMPANY:___________________________

PHONE: _____________________________

EMAIL: _____________________________

ADDRESS

ADDRESS: ___________________________

CITY:_______________________________

STATE: _____________________________

ZIP CODE:___________________________

CONTRAINDICATIONS OR CAUTIONS	YES/NO	
Cardiac pacemakers or other	O	O
electronically powered implants	O	O
Pregnant	O	O
Cardiac Fibrillation	O	O
Recently Consumed:		
Drugs or Alcohol	O	O
Sensitivity to Electrical Current	O	O
Lack of Sensation of Skin	O	O
Phlebitis or Thrombophlebitis	O	O
High or Low Blood Pressure	O	O
High or Low Blood Sugar	O	O
Severe Mental Disorder	O	O
Epileptic Tendencies	O	O
History of mental Illness	O	O
Organ Transplants	O	O
Cancerous Lesions	O	O
History of Fainting	O	O
History of Strokes	O	O
Botox Treatments	O	O
Recent surgery	O	O
Open Wounds	O	O

Medications

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Scars & Locations

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Major Complaints?:

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Waiver Of Liability

I understand that Avazzia devices impart electrical frequencies into the body. I have truthfully answered the above list of contra-indications for this therapy. Avazzia or QRS does not prescribe medical treatments or diagnoses. It is recommended that I see a physician for any physical ailment that I may have. I have stated all my known medical limitations. Considering the treatment offered, I agree that I will not institute any suit or claim against Avazzia, First Alternatives, FA Better Body, their representatives, or practitioners for any damage, loss, or injury to either person or property. I am in good health and have no physical limitations, which should affect my safe use of the devices. I additionally Authorize FA with Photo rights for distributing any pictures without my name for marketing purposes if appropriate. I am at least 18 years of age and otherwise legally competent to sign this agreement; This release shall be effective and binding upon my assigned and me.

Patient Signature

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Date: ________________

Printed Name: ________________

Practitioner Disclosure

I have, in trust & faith, advised the patient and recognize that the patient has been forthcoming with any questions I may have asked regarding any possible conditions that I may have foreseen within the wisdom of my practice:

Practitioner Initials: _________