

Inner Health Center Inc.

Therapy Waiver and Consent Form

I understand that the **Ear Candling Session** I will receive is provided for the basic purpose of helping unblock ear wax and debris, help with sinus issues, hearing loss, vertigo, ringing and itching, wax build up in a soothing and relaxing way. I further understand that a **Ear Candling Session** should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for mental or physical ailment that I am aware of.

Because a **Ear Candling Session** can be contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my intake form and understand that there shall be no liability in any way on the therapist's part or Inner Health Center Inc.

Patient's Signature

Patient's Name (Please Print)

Date