

Harmonic Light Waiver

For the diagnosis and treatment of any medical condition, consult a licensed physician.

Print Name: _____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone: _____ **Email:**_____

I am choosing to use harmonic light energy, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health. I fully understand that the attending demonstrators do not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments. In addition, they do not diagnose, treat or otherwise prescribe for my disease, illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited use of harmonic light energy and any attending practitioners' services in good faith, I am fully aware and release the practitioner to do a light energy session, wellness consultation and other stress reduction protocols. By signing below, I acknowledge that I have read and understand all parts of this consent form, that I had the opportunity to ask any questions with regard to the described procedures, and I hereby affirm: I am not here for medical diagnostic or treatment procedures and I am here on this and any subsequent visit solely on my own behalf.

Yes No 1. Are you currently pregnant?

Yes No 2. Are you taking photosensitive medicines where you have been guided to stay out of the sun by your doctor? If yes, consult your doctor prior to use.

Yes No 3. Are you epileptic or prone to seizures?

Yes No 4. Are you sensitive to light?

Yes No 5. Are you currently being treated for an active cancer?

Yes No 6. In the event that a LumiCeuticals Ambassador requests to use my image for promotion or marketing on a public website, social media or in print, I approve this use.

Your Signature:_____ **Date:**_____

Occupation: _____

Whom may we thank for your referral:_____

I am interested in improving my health and that of my family in the following areas

Stress _____	Pain _____	Inflammation_____	Inch loss _____	Anti-Aging _____	Energy_____
Mood _____	Skin _____	Circulation_____	Muscular Health____	Endurance_____	Bones_____
Nerves_____	Immunity____	Joint Health_____	Wound Health_____	Mental Focus_____	Sleep _____
Digestion____	Parasites____	Detoxification_____	Memory _____	Metabolism_____	Recovery____
Other_____					

Feedback *So We Can Better Serve You*

Name: _____

Best way to contact you: _____

1.) My overall rating of the light energy session today: 1 2 3 4 5 6 7 8 9 10

2.) Please comment on your results from the light energy session. I feel:

More Relaxed ____ **Less Pain** ____ **Energized** ____ **Lighter** ____ **Happier** ____
Other _____

3.) I value Harmonic Light. I am interested in additional sessions: **Yes** **No**

4.) I would like to learn more about how Harmonic Light Energy works. Yes ☐ No ☐

I prefer: A Workshop_____ A Webinar _____ Newsletter _____ Conference Call _____

5.) I have a friend or family member who would benefit from Light Energy. Yes No
They reside in: _____

6.) I am part of a group that would appreciate learning more about Harmonic Light.

7.) I would like more information about the following:

Experiencing more light energy sessions

Evaluating a Harmonic Light System at home in a two week trial. _____

Purchasing a Harmonic Light System for home use

Purchasing a Harmonic Light System for my business or practice _____

Helping others learn more about Harmonic Light

Marketing Harmonic Light Energy Technologies

Comments: _____
