PATIENT INFORMATION & RELEASE FORM
FOR INFRARED SAUNA

First Name: ___________________________Last Name: ________________________________

Date of Birth: __________________________ Sex: ________

Address: ____________________________________ City/State: ______________________ ZIP: __________

Telephone: __________________________ Email: __________________________________

Would you like to be added to our Email list? Yes / No

Emergency Contact & Phone Number: ____

Current Physician & Phone Number: ____

Health Concerns: ____
____

Have you experienced any major traumas? Y / N Explain: ____
____

Do you have any problems regulating your body temperature? Y /N: ________________________________

Do you have any dehydration concerns? ____

Current medications/supplements: ____
____

Do you have any infectious diseases? Y / N If yes, please identify: ___________________________________

Blood Pressure: ____________________ When & Where was it taken: ___________________________________

Do you have any reason to believe you may be pregnant? Y / N If yes, how far along are you?__________
Do you currently have, are undergoing or suffer from any of the following: a heart condition, a pacemaker, had a valve replacement, radiation or chemotherapy for cancer treatment, surgical implants or problems with blood clotting or are on a blood thinning medication? Y / N

If yes, please explain: ____
____

USER ACKNOWLEDGEMENT: ________ (Initials)

1. **Utilizing the Infrared Sauna under the influence of alcohol or drugs is PROHIBITED.** In the event of an emergency, Snow Blossom Acupuncture will be held harmless and not liable for any expenses or medical transport.

CANCELLATION POLICY: __________ (Initials)

1. **SBA LLC requires a deposit for all self-pay appointments at the time of booking**. The deposit may be used towards your visit cost. In the event a patient cancels in less than 24 hours' notice or no-shows, this deposit will be forfeited to SBA LLC.

My signature authorizes Snow Blossom Acupuncture, LLC (Kristen Taylor Wood, LAc. and/or Seth Wood, LAc.) to treat me with the medical grade infrared sauna. I have read and signed the Infrared sauna informed consent. As applicable to my treatment, the specific characteristics of infrared sauna therapy have been explained to me, and I understand the inherent characteristics and risks. I accept any responsibility for any damage that I create and will reimburse Snow Blossom Acupuncture, LLC for all costs. I understand that there are no guarantees concerning treatment and that I may refuse or stop treatment at any time.

Signature: ____________________________________ Parent/Guardian: ___________________________

Printed Name: _________________________________ Printed Name: _____________________________

Date: ____ Date: _____________________________________