M.A.C. Alternative Therapies, Inc.

28469 US Highway 19 No. #402, Clearwater, Florida 33761. Phone 727.723.3888 Fax. 727.796.2888

CONSENT FOR TREATMENT, AUTHORIZATION FORM, AND WAIVER OF LIABILITY

The undersigned (client/patient) hereby requests and freely consents to receive the performance of physical therapy, neuromuscular therapy, nutrition response testing analysis, physiotherapy, joint mobilization, supervised exercises, active isolated stretching, cranial sacral therapy, neuromuscular re-education, and/or massage therapy services from a treating and licensed therapist from MAC Alternative Therapies, Inc. and agrees as follows:

Client/patient understands and agrees that the therapy will be provided by a licensed LMT, NMT, DOM, DC, or PT of MAC Therapies and the therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any conditions. It is advised that all medical patients be followed by their primary or treating medical; provider.

Client/patient agrees to immediately inform treating therapist or physician of any unusual sensation or discomfort so that the application of pressure may be adjusted to client/patient level of comfort.

Client/patient understands that the treatment is not sexual in any manner and that any illicit or suggestive remarks or behaviors on client/patient part will result in an immediate termination of treatment or session.

Client/patient assumes full responsibility for receipt of all treatments and releases and discharges the treating therapist or physician and MAC Alternative Therapies, Inc. from any and all claims, liabilities, damages, actions or causes of action arising from their treatment received hereunder, including without limitation, any damages arising from acts of active or passive negligence on the part of MAC Alternative Therapies and or treating therapies or physician to the fullest extent allowed by law.

Client/patient in signing this consent, authorization and waiver of liability form understands and agrees that this consent will apply to and govern the current and all future therapy sessions performed by MAC Alternative Therapies, Inc and it's treating therapists, and/or physicians.

I agree and acknowledge that I am ultimately responsible to MAC Alternative Therapies for payments of any balance due, including unpaid deductible and/or unpaid percentage amount due according to my insurance policy cover ages. In the event MAC Alternative Therapies is unable to collect from my insurance carrier or attorney I attest that I will be fully responsible for payment.

As a courtesy to all patients, as well as the patients on the current "wait list" I understand that 24 hour notice is required for cancellation of appointments. Any missed appointments will be charged a missed appoint fee of up to $150.

I specifically authorize the natural health practitioners at MAC Alternative Therapies, Inc. to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include suggestions on dietary guidelines, nutritional supplements, etc, in order to assist me in improving my health, and **not** for the treatment, or "cure" of any disease. I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended. But rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing. This permission form applies to subsequent visits and consultations.

Date:____________________________________

Print Name: _______________________________Signed: ____

Print Name:_______________________________ If minor, signature of parent or guardian required)__________________________