



Healing With Dr. HERBert & Herb Shop

NOTICE OF DISCLOSURE AND CONSENT TO PARTICIPATE

Client Name: _____

Date of Birth: _____ **Date:** _____

NOTICE OF DISCLOSURE

Healing With Dr. HERBert & Herb Shop provides herbal products, wellness education, consultations, and therapeutic services intended to support general health and wellness. Services may include herbal wellness support, supplements, bodywork, reflexology, cupping, red light therapy, hydromassage therapy, and other wellness modalities.

I understand that these services and products are not a substitute for medical diagnosis, treatment, or care provided by a licensed healthcare professional. No specific outcome or result is guaranteed. Individual responses to herbs, supplements, and therapeutic services may vary.

I understand that herbal products may cause side effects, allergic reactions, or interactions with medications, supplements, and existing health conditions. I agree to consult an appropriate healthcare professional or pharmacist regarding potential risks, particularly if I am pregnant, breastfeeding, taking medication, or managing a medical condition.

I understand that therapeutic services may involve physical contact, pressure, heat, light, suction, or other techniques. Potential risks may include temporary soreness, tenderness, bruising, irritation, discomfort, or other reactions. I understand that I may ask questions, request modifications, decline a technique, or discontinue participation at any time.

I acknowledge my responsibility to provide accurate and complete information regarding my health history, medications, supplements, allergies, pregnancy status, injuries, and other relevant conditions that could affect the safety of the products or services I receive.

CONSENT TO PARTICIPATE

By signing below, I acknowledge that I have read and understood this Notice of Disclosure, had the opportunity to ask questions and receive answers, and understand the nature of the products and services discussed, including their limitations and potential risks.

I voluntarily consent to participate in consultations and therapeutic services specifically agreed upon and acknowledge that I may withdraw my consent at any time. This does not replace medical care, guarantee results, or illegally waive my rights.

Client Signature: _____ **Date:** _____

Parent/Legal Guardian Signature (if applicable): _____

Practitioner/Representative: _____