Third Space Wellness, LLC

CONSENT TO SERVICES

I, _____, understand that TSW Services (as defined below) are provided by Third Space Wellness, LLC ("TSW") staff and/or affiliated practitioners ("Clinicians"). I understand that this agreement covers the Clinician or Provider who initially treats me and any other Clinicians or Providers associated with TSW who may provide my treatment in the future.

I hereby give my consent to receive the following TSW Service:

Nutritional Counseling and Dietary Supplements: [Initial to opt out: _____]

Recommending use of foods, diet plans or dietary supplements. Dietary supplements include plants/botanicals, minerals, vitamins, amino acids, and animal materials. May be in the form of teas, pills, powders, tinctures (may contain alcohol), topical applications, suppositories, or other forms.

Potential Risks: I understand that, while not common, side effects can potentially occur from herbal medicines and dietary supplements. Some examples include, but are not limited to: headaches, skin rashes, digestive upset, or less commonly, allergic reactions to recommended herbs or supplements. Nutritional evaluation or testing provided in Nutritional Counseling is not intended for the diagnosis of disease. Rather, these evaluations are intended as a guide to developing an appropriate health supportive program for me, and to monitor my progress in achieving my goals.

Medical Treatment: Our Clinicians are not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as my physician and I deem it necessary. It is my responsibility to consult with my physician before altering any prescribed medications or treatments. I understand also that if there is an emergency, or a worsening of my health condition, or if a new condition arises, that I should consult a licensed physician.

Voluntary: I hereby request and consent to receive TSW Nutritional Counseling and Dietary Supplements Services. I have not been guaranteed any specific outcomes concerning the uses and effects of any TSW Service. I understand that I am free to discontinue any TSW Service at any time. I voluntarily assume all risks inherent in the nature of each of the TSW Services. I waive all claims, costs, liabilities, expenses and judgments against TSW and release TSW and its members, officers, agents, representatives, and employees from all claims, costs, liabilities, expenses, and judgments arising out of the TSW Service.

By voluntarily signing below, I confirm that I have read, or have had read to me, and understand the above Consent to Services, have been told about and understand the risks of each of the TSW Service, and have had an opportunity to ask questions and have received satisfactory explanations. I understand that I can request more information at any time if desired. I understand that I have the right to refuse or discontinue any service any time and that this refusal may affect the expected results I am seeking. I intend this consent form to

cover the entire course of treatment for my present condition and/or my current wellness goals, as well as for any future condition(s) and/or goals for which I seek these services.

PLEASE PRINT:

Print Patient Name	Patient Birth Date
Street Address	City, State and Zip Code
Email Address	Preferred Phone Number
Emergency Contact Name	Emergency Contact Phone Number
Signature (or parent or guardian signature if client is a minor)	Today's Date

☐ Please exclude me from your mailing list.
We do not sell our mailing list.

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