Client Intake Form

JustQuit Laser Therapy, 902-446-4465

Name: ____

Phone Number: ____________ Email: ______________________

Date of Birth______________: Emergency Contact and phone number_______

____________: Relationship: ______________________________

Insurance Provider: _______________

Policy Number: _________________

ID Number: ___________________

***If you are on your spouse's insurance policy, we will need the following:

Spouse's Name: _______________ Date of Birth________________

Which service are you booked for?

Smoking addiction __ Weight Appetite/Hunger Control __ Substance Abuse__

Stress Management __

Do you have any of the following conditions?

Cancer __ Pace Maker __ Heart Condition __Pregnant __Seizures __

Do you have any other Medical Condition(s) that Just Quit Laser Therapy should be aware of? YES or NO If YES....Please list the condition(s):_______________

____

Waiver:

The undersigned has read, understands and agrees to the following statements:

JustQuit Laser Therapy does not diagnose or treat any disease or medical condition. Before taking any vitamins or supplements the undersigned will consult their Physician/Pharmacist. The undersigned agrees to hold JustQuit Laser Therapy and its' owners, officers, directors,
managers, and employees harmless of any and all liability related to the Just Quit Laser Therapy system. JustQuit Laser Therapy does not issue any guarantee and the company does not make any promises regarding individual results therefore we understand that JustQuit Laser does not offer refunds on any treatments. The undersigned authorizes JustQuit Laser Therapy to do the follow up phone calls to the numbers supplied.

NOTE: Boosters are usable ONLY if you don't smoke. Once you inhale any amount of Nicotine the full treatment is require again.

CLIENT SIGNATURE:_____________________DATE:___________

THERAPIST SIGNATURE:___________________DATE:__________

I allow JustQuit Laser Therapy to email all sales and promotions.

Client Signature_________________________

COVID-19 Informed Consent for Treatment

The novel human coronavirus SARS-CoV2 is a viral pathogen primarily affecting the respiratory tract. The disease this virus causes has been named COVID-19; it has been named a global pandemic. Coronavirus is spread by respiratory droplets generated when coughing or sneezing entre the body through the eyes, nose or mouth. It can also be transmitted by touching something or someone that the virus is on, then touching your mouth, nose or eyes before washing your hands. Coronavirus appears to have a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

To proceed with receiving care, I confirm that I understand the following (please initial each box)

☐ I understand symptoms of COVID-19 can vary between people, but I can confirm that I do not currently have, nor have experienced the symptoms listed below within the last 14 days. If I do have any of these symptoms from an underlying or chronic condition, I confirm that they are not worsening for any unknown reason.

- fever (chills, sweats)
- cough
- worsening of a previous cough
- sore throat
- headache
- shortness of breath
- muscle aches
- sneezing
- nasal congestion or runny nose
- hoarse voice
- diarrhea, nausea, vomiting
- unusual fatigue or loss of sense of smell or taste
- red, purple or bluish lesions on the feet, toes, fingers without clear cause

☐ I confirm that I, as well as all household members, have not been diagnosed with COVID-19 within the last 30 days, nor am I currently awaiting test results for COVID-19

☐ I confirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the past 30 days.

☐ I verify that I have not returned to Nova Scotia from any other province or country whether by car, air, bus or train in the past 14 days.

☐ I understand that Nova Scotia Public Health has asked individuals to maintain physical distancing of at least 2 metres (6 feet) whenever possible, but that it is not possible to maintain this distance and receive acupuncture treatment.

☐ I am informed that the clinic has implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be a risk of becoming infected with COVID-19 by proceeding with this treatment.

☐ I understand that Acupuncture, Herbal Medicines and other forms of Traditional Chinese Medicine are not substitutes for seeking medical care for COVID-19

☐ I release the clinic/practitioner from any legal claims should I become infected with COVID 19

☐ I promise to alert the clinic/practitioner should I test positive for COVID-19 within 14 days of treatment

☐ I give permission to my practitioner to supply the Public Health Office with my Name and Contact information should it become necessary during "Contact Tracing" procedures by the government

☐ I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks Associated with receiving care during the covid-19 pandemic.

☐ I confirm all of my questions were answered to my Satisfaction.

Name of Patient (print) ____

Signature of Patient ____ Date: ________

Signature of Practioner ____ Date:________