THE BEAUTY OF
AYURVEDA

The Beauty of Ayurveda Service Liability Waiver

Client Name: _____

Date: _____

Signature: _____

Sex: □ Male □ Female □ Other: _____ **Age:** _____ **Height:** _____**Weight:**_____

Phone: _____

Email: _____

Statement of Understanding & Informed Consent

I understand that the Ayurvedic spa therapies, yoga instruction, and Ayurvedic counseling services provided at *The Beauty of Ayurveda* are offered by Lisa Scarborough, an Ayurvedic Practitioner. I acknowledge that Lisa Scarborough is **not a licensed medical doctor**, and does not diagnose, treat, or prescribe remedies for diseases, disorders, or other medical conditions.

I understand that Ayurvedic consultations and body therapies are not a substitute for medical diagnosis or treatment. If I have current or chronic medical concerns, I acknowledge it is my responsibility to seek appropriate medical advice and care from a licensed healthcare provider. I further agree that any medications I am taking or may need to take are solely under the guidance and authority of my prescribing physician.

I acknowledge that during my Ayurvedic intake and treatments, I may be asked to disclose health-related information. I understand this information is considered **private health information (PHI)** and will be kept confidential in secured storage. I may request in writing to have this information destroyed or access revoked at any time.

Waiver of Liability

In consideration of receiving services from *The Beauty of Ayurveda*, including but not limited to Ayurvedic counseling, body therapies, and yoga sessions:

- I **voluntarily assume all risks** related to these services.
- I hereby **release and hold harmless** Lisa Scarborough, *The Beauty of Ayurveda*, and *Vault/Prodigo* from any and all liability, claims, demands, or causes of action that may arise from participation in any services offered.
- This waiver includes, without limitation, injuries or conditions that may result from service participation, whether caused by negligence or otherwise.

I confirm that I have read, understood, and agree to all terms described above. I am signing this form voluntarily and acknowledge that I may revoke my authorization to share PHI or consent to treatment at any time in writing.

Client Signature: _____

Date: _____

Printed Name: _____