CONSENT TO RECEIVE BIOFEEDBACK TRAINING FROM DR. PETER FISCHER

I understand Dr. Peter Fischer is ***not licensed*** as a chiropractor, counselor, medical doctor, psychologist or psychotherapist and does not portray himself as such.

I understand, he will not diagnose, evaluate, treat, cure, mitigate or prevent any nutritional, medical or psychological disease, disorder or condition.

I further understand he will not advise, recommend, suggest or counsel me on any medical, dietary, emotional or psychological treatment, condition, disorder or disease of any kind.

I further understand it is my responsibility to continue my medications and remain under the care of my primary physician.

CREDENTIALS

I understand Dr. Peter Fischer is a ***Certified Biofeedback Specialist*** with the Board of Natural Therapies (he is a Certified Health Coach, Certified Homeopathic Therapeutic Coach and Certified Nutritionist) and he will train me with biofeedback for relaxation and muscle re-education so I can learn to reduce my stress, manage my pain, and improve the quality of my life. I further understand that he will refer me to qualified experts for any other concerns I have about my health and wellness.

SCOPE OF BIOFEEDBACK PRACTICE

I understand the intended purpose of biofeedback training is for relaxation and muscle re- education so I may learn to:

1) reduce my stress,
2) manage my pain, and/or
3) improve the quality of my life.

I understand biofeedback training is generally considered safe, but it is possible that biofeedback may exacerbate some emotional problems or I may become drowsy, at least temporarily, during the biofeedback training sessions. Other potentially harmful side effects not yet reported may occur. I agree to advise Dr. Peter Fischer anytime I feel any side effects, so corrective steps may be taken to alleviate my discomfort.

I further understand biofeedback is not a substitute for effective standard medical, chiropractic or psychotherapy treatment or veterinary treatment for my pet. (Your name) has advised me to continue ongoing medical treatment and therapies until otherwise advised by my psychotherapist, physician or medical practitioner. I understand it is important for me to stay in close communication with my physician. I further understand it is my responsibility to ask my medical doctor for permission to undergo biofeedback training if I wear a pacemaker or have any medical condition that may be exacerbated by relaxation.

I understand it is my responsibility to monitor the effects of biofeedback training and to continue the training as long as it is beneficial to me. I will tell Dr. Peter Fischer anytime I experience any discomfort during biofeedback training. I further understand that research suggests that while most people gain considerable benefits from biofeedback training, some people may not gain any benefit. I have every expectation that biofeedback will provide me some benefit, but I understand there is no guarantee that it will.

DISTANCE TRAINING - SUBSPACE

I understand that Quantum or distance training can be described as the utilization of
uniting the mind-body-spirit in promoting the individual to self-heal. I also understand that quantum or distance training is voluntary and Dr. Peter Fischer with his training techniques is the mercy the facilitator of the energies and guides them in the process utilizing quantum training tools.
I hereby request and consent to the technique of energy or distance training modalities within the scope of Dr. Peter Fischer's training techniques

By signing below, I acknowledge that I have read and understand this document, and have received acceptable answers to all of my questions about biofeedback services. I consent to receive biofeedback training from Dr. Peter Fischer. I warrant I am not under duress at this time and my consent is given voluntarily and without coercion. I further understand I may discontinue biofeedback training at any time and that I may refuse to participate in any particular or specific biofeedback training without penalty.

Name of Client_____

Address_____

State_____Postal Code_____

Signature_____Date_____

Name if other than client_____

Relationship to client _____

FOR PARENTS/GUARDIANS OF MINOR CLIENT/ ANIMAL OWNER
I attest that I have full legal authority to make decisions for the minor named below, and that I give my permission for him/her to undergo biofeedback training.

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Parent/Guardian's Signature Guardians Name Date