



INFORMED CONSENT FORM

Name: _____

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Phone: _____

How did you hear about us? _____

- ☐ I am over the age of 18
- ☐ I am under the age of 18 – my parent or legal guardian is filling out and signing this form on my behalf
- ☐ I am not pregnant or nursing
- ☐ I do not have a pacemaker, magnetic chip implant, including an insulin regulator, or any other electronic implanted device, implanted stimulator or battery operated electronic implant
- ☐ I do not suffer from, or have been diagnosed with, Epilepsy or any other seizure-related disorder
- ☐ I agree that if I have any metal implants, screws, plates, joints or other metal in my body that may be affected by a strong electromagnetic field I will not place the Coil directly on those areas
- ☐ I agree that if I have multiple amalgam fillings that I will not place the coil directly on my head area
- ☐ I agree that if I have body staples, such as gastric bypass, that I will not place the Coil directly over the staples and that I use the AmpCoil at my own risk
- ☐ All electronic devices, metal, cell phones, watches, magnetic jewelry, credit cards, hearing aids, keyless entry and other electrically sensitive materials will be removed before an AmpCoil PEMF session, and placed four feet away from the active coil

I understand that the AmpCoil System is a PEMF and voice analysis Biofeedback device that generates a non-invasive pulsed electromagnetic field, emitting a series of pulsing electromagnetic frequencies (PEMF). The AmpCoil System is intended to study the effects of voice directed PEMF sound transmission on the body.

The AmpCoil PEMF system is not a replacement for any standard medical treatment. The AmpCoil System is not intended for use in the diagnosis, treatment, cure, mitigation or prevention of any disease, medical condition, physical or psychological disorder. It should not be considered a replacement for medical advice or treatment. If you have a serious, acute, or chronic health concern, please consult a trained health professional who can fully assess your needs and address them effectively.

I hereby release Optimum Function, LLC, and all of its agents, officers, representatives, and employees from and against any and all losses, liability claims, damages, injuries, demands, actions and causes of action whatsoever, arising out of, or related to, my use of the PEMF and Biofeedback system.

By signing below, I acknowledge that I have read and understand this document and been given the opportunity to receive responses to any questions I have regarding PEMF and Biofeedback and my participation therein. I consent to receive PEMF and biofeedback session(s). 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 PEMF and biofeedback session(s) at any time.

NAME: _____
Please Print

SIGNATURE: _____

DATE: ____/____/____ Administered by: _____