

AKN Medical Waiver

Client Information:

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email: _____

Service Provider Information:

Name: _____

Address: _____

Phone Number: _____

Email: _____

I, the undersigned client, hereby acknowledge and agree to the terms, pricing, timeframe, and potential results of the services provided by the above-mentioned service provider. I understand that the services offered may involve medical procedures, treatments, or consultations, and I am aware of the potential risks and benefits associated with these services.

Terms and Conditions:

1. Consent: I give my informed consent to receive the services provided by the service provider, understanding the nature of the procedures or treatments involved.

2. Pricing: I acknowledge that I have been provided with a detailed breakdown of the pricing structure for the services I will receive. I understand that additional charges may apply if any unforeseen circumstances or complications arise during the provision of services.

3. Payment: I agree to pay the agreed-upon fees for the services provided by the service provider. I understand that payment is due at the time of service or as otherwise arranged.

4. Timeframe: I acknowledge that the service provider has provided an estimated timeframe for the completion of the services. I understand that the actual duration may vary depending on various factors, including my individual circumstances.

5. Results: I understand that the results of the services provided may vary depending on individual factors, including my health condition, lifestyle, and adherence to any post-treatment instructions provided by the service provider.

6. Risks and Benefits: I acknowledge that the services provided may carry certain risks, which have been explained to me by the service provider to the best of their knowledge. I understand that the potential benefits of the services may not be guaranteed, and individual results may vary.

7. Confidentiality: I understand that the service provider will handle my personal and medical information with the utmost confidentiality, in compliance with applicable laws and regulations.

8. Alternative Options: I acknowledge that I have been informed of any alternative options available for the services I seek, including potential risks and benefits associated with those alternatives.

9. Release of Liability: I hereby release the service provider, their employees, contractors, and affiliates from any liability arising from the provision of the services, except in cases of willful misconduct or gross negligence.

10. Governing Law: This waiver shall be governed by and construed in accordance with the laws of the jurisdiction in which the services are provided.

I have read this medical waiver and understand its contents. I have had the opportunity to ask questions, and any concerns I had have been addressed

to my satisfaction. By signing below, I indicate my agreement to all terms and conditions stated herein.

Client's Signature: _____

Date: _____

Service Provider's Signature: _____

Date: _____