

CONSULTING AGREEMENT

NAME:

AGE:

ADDRESS:

CITY:

STATE:

ZIP:

DAYTIME PHONE:

EVENING PHONE:

E-MAIL:

MOBILE PHONE:

DATE:

WAIVER AND RELEASE

I acknowledge that Vijay Vaishnav and/or Daxa Vaishnav (*Service Providers*), who practice Classical Homeopathy, have each completed six years of college education in Homeopathy and hold a M.D. (Doctor of Medicine) degree in Homeopathy from Dr. Babasaheb Ambedkar University in Aurangabad, India, a school accredited by the Central Council of Homeopathy, New Delhi, India. Each of them has over twenty-five years of experience in Classical Homeopathy. They have also taught Homeopathy for over twenty-five years at C.M.P. Homeopathic Medical College, Mumbai, India.

I acknowledge that *Service Providers* are not licensed physicians in the State of California and are providing services under Sections 2053.5 and 2053.6 of California's Business and Professions Code, subject to requirements and restrictions. I understand that the nature of the services provided by them involves an interview to gather the information needed, analysis of this information, recommendation of a homeopathic remedy and assessment of the action of the remedy at follow up consultations. I further acknowledge that their services are alternative or complementary to healing arts services licensed by the State of California, are therefore limited in scope, and not a substitute for medical supervision and advice.

I acknowledge that I am seeking alternative therapy in the form of lifestyle, educational, nutritional, and homeopathic advice and/or recommendations. I am not seeking diagnosis or treatment of specific medical, pathological or psychological conditions, but rather an enhanced state of overall mental, emotional, and physical wellbeing. I affirm that if I desire a diagnosis or treatment for any medical condition, I must consult a physician.

I understand that the outcome of homeopathic advice varies by individual, and is not guaranteed.

I understand that the homeopathic remedies recommended by *Service Providers* are FDA approved, safe and available over the counter in USA. I also understand that I can willingly exercise the choice of purchasing these remedies directly from *Service Providers*, who acquire them in bulk from homeopathic remedy manufacturers and repackage them in smaller volumes for cost saving purposes. I understand and affirm that in the services provided by *Service Providers*, nothing whatsoever is intended to diagnose,

mitigate, prescribe, treat, cure or prevent any disease or illness or symptoms as defined by the FDA and the State of California, nor do *Service Providers* treat, prevent, or mitigate adverse events associated with a therapy for a disease.

I hereby, on behalf of myself and my heirs, executors, administrators waive, release, remise, discharge and hold *Service Providers* harmless from any liability resulting in any possible damages or loss during our association. I hereby assume all risks of personal injury, death, or other damages which may result with my association with *Service Providers*. I hereby indemnify and hold harmless *Service Providers* from any and all claims, damages, costs or liabilities including attorney's fees and costs, based on or in any way related to the homeopathic remedies and/or recommendations which I (or my child) receive.

I have received a copy of this Consulting Agreement.

Date:

Signature (of parent in case child is minor):

Name (printed):