



# Salt Cave Halotherapy & Wellness Centre

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First Name:

Last Name:

Date of Birth:

Gender:

Address:

Mobile No:

Phone No:

Email:

Medical condition information/Allergies if any:

List any long-term medication you are using:

Please list any other medical condition or issues other than those listed above that may affect the wellness service that you are going to receive today (for example FEMALE CLIENT can state whether they are PREGNANT):

Wellness service chosen:

Voucher Number:

Voucher Source:

Voucher Amount:

Cash Sale (If Not Voucher):

**Introduction:** "I have been given sufficient information on the wellness service I have chosen at Salt Cave Halotherapy & Wellness Centre, that allows me to make an informed consent. I understand that, I have the right to ask questions and clarify any doubts I have about the wellness service I am interested in at Salt Cave Halotherapy & Wellness Centre before undergoing any procedures."

**Cost:** "I understand that the cost of my wellness therapy service / treatment at Salt Cave Halotherapy & Wellness Centre is agreed by both parties."

**Risks of consent for treatment:** "I have read and understood the information provided on the Salt Cave Halotherapy & Wellness Centre's website regarding the wellness service I have chosen; particularly the indication, contraindication, and adverse reaction information."

**By signing this informed consent:**

- I am stating that I have read and / or the wellness service procedure has been described to me to my satisfaction.
- I fully understand the treatment and the possible risks, complications and benefits that can result from the wellness therapy product treatment I have chosen at Salt Cave Halotherapy & Wellness Centre.
- I have disclosed my medical conditions (if any) to Salt Cave Halotherapy & Wellness Centre.
- I agree to undergo the treatment as described.
- I hereby confirm that, I will present myself in a respectful and professional manner throughout time I am at the centre. This behaviour will be extended to staff and other clients present at the Centre.
- I understand that failure to act in an acceptable manner will be dealt in an appropriate manner and we may be obliged to seek legal action.

Date:

Client Signature:

Provider Signature: