

INFORMED CONSENT

NAME _____ AGE _____
ADDRESS _____ OCCUPATION _____
CITY/STATE/ZIP _____
PHONE _____ E-MAIL ADDRESS _____

PLEASE LIST YOUR MAIN COMPLAINTS.

PLEASE LIST ANY MAJOR SURGERIES

PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKIING.

PLEASE READ THE FOLLOWING AND SIGN BELOW.

Breast Research Awareness & Support, LLC. (BRAS) uses an MSAS Pro to provide a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the procedure is to disclose patterns of stress and to provide feedback to help restore each system and meridian (energy pattern) back to balance.

I understand that BRAS does not provide a medical diagnosis, and that my testing technician may recommend further medical testing. If you suspect that you need further medical intervention, YOU should consult YOUR physician.

I give my permission for the testing technician to evaluate me on the MSAS Pro system. I understand that by doing so, the testing technician is not becoming my primary care physician.

I understand that the testing technician will give me information about myself based on the evaluation and that the testing will make recommendations to balance my system based on what is found. Any decision to follow through with the program will be my own decision, and I will not hold the testing technician responsible.

DATE _____ CLIENT SIGNATURE _____
DATE _____ TECH. SIGNATURE _____