



Name: _____

Address: _____

City, State, Zip _____

Phone Number: _____

(Your personal information is for our insurance requirements only and will not be shared with anyone.)

The Salt Haven, LLC does not claim to be a replacement for medication or any medical treatment of any kind. Only your personal physician or other health professional can best advise you on matters of your health. The research supporting the use of Salt Care was undertaken outside of the USA and hasn't been filed with the FDA for approval.

Salt Care should be avoided during the acute phase of any illness, including the following: infections accompanied by fever, acute active tuberculosis, cardiac insufficiency, COPD in third stage, bleeding, spitting of blood, contagious ailments, have use of an oxygen tank to aid breathing, alcohol or drug intoxication, unstable or uncontrolled hypertension, acute stages of respiratory diseases and individuals actively taking chemotherapy.

I understand that the salt therapy I receive at **The Salt Haven, LLC** is provided for relaxation and wellness support. If I experience any pain or discomfort during this session I will leave the salt room and immediately inform the employee on duty. I further understand that halotherapy should not be construed as a substitute for professional health care; and that I should obtain the services of a physician or other qualified healthcare specialist for my healthcare needs. I acknowledge that the representatives of **The Salt Haven LLC** are NOT qualified to diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of my visit here should be construed as such because halotherapy should not be taken by individuals with certain medical conditions. I affirm that I have stated all my known medical conditions and answered all questions honestly. Also, I affirm that I do not have the conditions noted above that would make receiving halotherapy inappropriate. I agree to notify this establishment of any changes in my medical profile. I agree to the terms noted above and absolve **The Salt Haven, LLC** of any liability in regard to any reactions, real or perceived, that I may experience after receiving salt therapy at this facility.

Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Please see reverse to read and sign COVID Waiver ⇨⇨⇨

COVID-19 Liability Waiver

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that The Salt Haven LLC has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I further acknowledge that The Salt Haven LLC cannot guarantee that I will not become infected with the Coronavirus/COVID-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including but not limited to, staff and other customers and their families.

I voluntarily seek services provided by The Salt Haven LLC and acknowledge the risk of possible exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my session.

I attest that:

- I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, headache, sore throat, or new loss of taste or smell
- I have not traveled internationally for the last 14 days
- I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
- I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities
- I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19

I hereby release and agree to absolve The Salt Haven LLC of any liability in regard to any reactions, real or perceived that I may experience after receiving salt therapy at this facility

Printed Name: _____

Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____