**Consent Form**

By participating in this event, I consent Sarah LoBisco, ND to offer education and suggestions in optimizing my diet, nutritional supplements, and lifestyle changes for the purpose of reducing stress, optimizing emotional wellness, and enhancing my life during Dr. Sarah’s Community Membership Events and BreakFree Medicine teleseminar series. It is my responsibility to discuss any changes with my health care provider and disclose any information to my health care provider regarding any allergies, medications, or sensitivities that may interfere with my current healthcare and/or the use of such supplements, essential oils, and lifestyle changes. I take full responsibility for implementing any changes in my healthcare regime and release Dr. LoBisco from any liability.

**Disclosure Form**

I understand that Dr. ­­­­­­­­­­­­­Sarah LoBisco has a degree in naturopathic medicine from the University of Bridgeport, College of Naturopathic Medicine, a federally accredited school in CT. I understand that New York does not currently regulate or license Naturopathic Medicine, but Dr. LoBisco holds a license in the State of Vermont.

I understand that these sessions may be recorded for future use and can be viewed by others in the group and others who purchase content in the future. If I ask questions and participate, I am providing consent for Dr. LoBisco, as BreakFree Medicine, to produce, reproduce, edit, print, trade, and/or share content (including videos, photographs, images, likeness, sound, statements, or comments) as desired. I waive all the right to compensation and royalties. By participating in the group seminar I acknowledge that I am not breaching any other contracts with any other applicable business entity or school.

**Disclaimer**

I understand that naturopathic medicine and this event is not intended as diagnosis, treatment, prescription or cure for any disease, mental or physical, and is not intended as a substitute for regular medical care in the State of New York. I realize that I am a willing participant responsible for my health care and acknowledge that Dr. LoBisco, ND is a partner of my wellness team. This consent form is binding until I no longer wish to be in Dr. LoBisco’s care, which I must inform her in writing.

Date: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_