7 Senses Kids
OT STUDIO & ECO SHOP

7 SENSES THERAPY SCREENER

(Please circle Y for Yes and N for No)

FINE MOTOR

Pre-Writing Skills

Does your child grasp (hold) the writing tool differently from other children? Y N

Is your child's handwriting (spacing, letter formation and or placement) difficult to read and follow? Y N

Does your child express dislike, hand fatigue or discomfort during writing tasks? Y N

Does your child color outside the lines? Y N

Does your child press light/hard on the paper when coloring, writing, or drawing? Y N

Object Manipulation Skills

Does your child have difficulty picking up small items such as jelly beans or cereal from a flat surface? Y N

Using the same hand, does your child have trouble moving objects from their palm into their fingertips? (Ex. Placing 2 or more coins into a vending machine) Y N

Does your child find it difficult to perform self help tasks such as buttons, zippers, snaps, and or shoe tying? Y N

Does your child drop items frequently? Y N

Does your child have difficulty using scissors to cut? Y N

Total number of No's:_____

GROSS MOTOR

Range of Motion and Strength

Does your child avoid physical play, such as jumping rope, or playing ball? Y N

Does your child need more help to throw or kick a ball? Y N

Does your child appear to get tired quickly when engaged in a physical task? Y N

Does you child display poor posture when sitting at the table or when playing? Y N

Does your child find it difficult to maintain certain positions such as standing on one foot or balancing? Y N

Coordination

Does your child have difficulty riding a bike, tricycle, or scooter..etc? Y N

Does your child appear clumsy when walking, jumping, or running? Y N

Does your child need help completing the sequence to a motor task, such as step by step directions to cross the monkey bars, slide down the slide, or climb up a playground ladder? Y N

Does your child have difficulty aiming at a target when throwing or trouble catching or hitting a tossed ball? Y N

Does your child have difficulty attaining a new skill, such as swimming? Y N

Total number of No's:_____

SELF-HELP SKILLS

Activities of Daily Living

Does your child have difficulty completing age appropriate tasks such as: getting dressed, washing hands, brushing teeth, toileting, or combing hair? Y N

Does your child have difficulty using utensils appropriately when eating? Y N

Does your child have trouble recognizing left from right or vice versa? Y N

Does your child have difficulty completing chores around the house or other jobs that require sequencing, such as making the bed, or pouring a bowl of cereal? Y N

Does your child need help staying on task and following directions? Y N

School Tasks

Does your child have trouble organizing papers for school or keeping a neat desk? Y N

Does your child have difficulty carrying the lunch tray to the table? Y N

Does your child need help following verbal instructions to complete activities or assignments? Y N

Does your child forget or lose track of items during the school day? Y N

Does your child need assistance to open containers and other lunch items? Y N

Total Number of No's:_____

SENSORY PROCESSING

Self-Regulation

Does your child enjoy running, jumping, crashing and have lots of extra energy? Y N

Does your child have a short attention span? Y N

Does your child have less energy and appear more passive than other peers? Y N

Does your child overly enjoy (always want) movement tasks such as swinging, jumping, and sliding? Y N

Is your child nervous of movement tasks such as swinging, climbing, and sliding? Y N

Senses

Is your child a picky eater? Y N

Does your child have sensitivities to certain textures/activities, such as clothing, play-doh, lotions, haircuts, nail trimming, interacting with peers or attempting messy play tasks? Y N

Does your child display repetitive behaviors, such as lining objects up, or opening and closing doors…etc? Y N

Does your child have an increased sensitivity to sounds or a decreased sensitivity to sounds? Y N

Does your child appear unhurt after falling or having an accident? (ex: not crying at all after skinning their knee) Y N

Total Number of No's:_____

2261 Town Center Ave #109 Viera, FL 32940

321-255-7779 phone

321-255-7774 fax

7sensestherapy@gmail.com

www.7sensestherapy.com

7 Senses Kids
OT STUDIO & ECO SHOP

Attendance/Cancellation Policy

The staff at 7 Senses Therapy, LLC are devoted to assisting families and children attain their full potential in life. We work closely with our families to achieve the goals that are important for each family and child. **Regular and consistent treatment plays a critical role in your child's progress and ability to achieve goals.** In order to help your child reach their goals and receive high quality pediatric services, we have established an attendance policy and guidelines.

Evaluation Attendance Policy

Please arrive 10 minutes prior to your child's evaluation to make sure paperwork is in order. Evaluations are approximately 45- 60 minutes long. A non-refundable $50.00 was collected at booking to cover a canceled evaluation, but will be applied to the balance on the evaluation day if not cancelled.

Session Attendance Policy

Please arrive on time for sessions as they range from 30-60 minutes. If you are tardy for a session, we cannot extend your scheduled time slot. You will still be charged for the entire scheduled time slot. **A late cancel is 2 hours or less from the appointment time, resulting in the session being charged. If you cancel any of your sessions, for any reason, our policy states you have 15 days to reschedule the cancelled session. If you do not reschedule, you will be charged for the session. You must accept any day and time offered which may be different from your weekly time. Any No Show, results in the full session price charge.**

Our therapists are dedicated to helping our clients achieve their goals through research based interventions; this requires extra planning time and effort to customize each child's session outside actual therapy times. We ask our clients to share the same dedication, courtesy, and respect to commit to the agreed-upon schedule of appointments and therapy program.

We have the right to move your time slot or discontinue services at any time if the attendance policy is not followed. Therapy is very important and consistency is necessary to ensure success. We have many families waiting for specific times and your time slot may become eligible.

Fee reminders
No-show: results in the session being charged
Late cancel: two hours or less from appt time, results in the session being charged
Regular cancel: allows for a 15 day rescheduling period, if the session is not rescheduled it results in the missed session being charged.

Reschedule your missed sessions to avoid the fees

I have read and understand 7 Senses Therapy, LLC Attendance Guidelines and Cancellation Policy and agree to comply.

Parent/Guardian Signature X_____Date:_____

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7 Senses Kids
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"Gaining Skills for Life!"

Informed Consent Form/Indemnity 2026

I _____(Parent/Guardian – please print)
of_____ (Child's name) hereby, authorize and give my permission and consent to 7 Senses Therapy, LLC and/or 7 Senses Kids to perform evaluations, therapeutic treatments, and/or area specific classes/tutoring as prescribed by a physician and/or recommended by a 7 Senses Therapy, LLC Occupational Therapist or Speech Therapist or by myself for the above named child. I acknowledge and understand that there may be some inherent risk involved in the use of therapy equipment and/or therapeutic services. I agree to assume such risk and indemnify and hold 7 Senses Therapy, LLC and/or 7 Senses Kids and any and all employees harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child, and/or our belonging. I hereby indemnify and save harmless 7 Senses Therapy, LLC and/or 7 Senses Kids and any and all employees harmless from and against any and all claims, loses, damage and injury whatsoever, including without limitation, reasonable attorneys' fees and court costs, arising out of or in connection with (i) any occurrence in the therapy studio or any occurrence in any other area of the Shopping Center including without limitation the sidewalks, parking lot and driveways adjacent to and serving 7 Senses Therapy, LLC and/or 7 Senses Kids (ii) any occurrence offsite located away from the therapy studio. The client will protect and hold the Indemnified Parties harmless and will pay on demand all costs, expenses and attorney fees to defend the Indemnified Parties in connection with such litigation, dispute, arbitration, negotiation or proceeding with counsel chosen by the Indemnified Parties. This indemnity shall survive the expiration or earlier termination of services.

I understand that I will be informed of the recommended services of the above named child. I acknowledge and agree that a parent or legal guardian must be present or on the premises during each session, unless I have signed the drop off release form.

7 Senses Therapy, LLC, also reserves the right to discontinue services for any and all reasons including but not limited to: excess cancellations, failure to pay for services, missed sessions or no shows.
I have carefully read and reviewed this Informed Consent Form and have had my questions answered by the 7 Senses Therapy, LLC Occupational Therapist if necessary.

Current 2026 Pricing

1.Initial Eval: $349.00 (50.00 non refundable deposit when scheduled).
2. Parent only education session to review evaluation and program moving forward (79.99-99.99)
3. First treatment session with child (79.99-99.99), OFFSITE pricing: 102.99 (30-45min)
4. re-eval: $299.00 (will decide with parents if more therapy is warranted or if new goals should be worked towards or if it's time to discharge with a home program to maintain skills.)

X_____ _____
Signature of Parent/ Legal Guardian Date



CREDIT CARD ON FILE AUTHORIZATION FORM

This form is for you to supply 7 Senses Therapy, LLC with credit card information to keep on file for the payment of all services and fees. A new form must be completed for each card kept on file. 7 Senses Therapy, LLC accepts: Visa, MasterCard, Discover, Am. Express. In the event payment for services is denied by Gardiner scholarship or Tricare, 7 Senses Therapy will charge the card on file for service dates.

Card Information:

Card Type (Circle): Visa / MasterCard / Discover / ***CARE CREDIT- please fill out what is needed for care credit, must also have a copy of driver's license***

Name on Card: _____

Card Number: _____

Expiration Date: _____ *CVV Code (Security Code):* _____

*Zip Code*_____

Cardholder Signature: _____

Please list anyone other than the cardholder that is authorized to use this credit card.

Name: _____

Date: _____

Cardholder Signature: _____

PLSA Gardiner Scholarship Clients: Client Name:_____ Student ID #:_____

*****We must have a credit card on file for scholarship students as well in the event we are not able to receive payment from scholarship, and must collect payment for services, thank you******

☐ **My card is on file, but I do not want to write info down on the form.**

I hereby authorize 7 Senses Therapy, LLC to charge the credit card listed above/ and or on file for the payment of all services and fees. This credit card will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may revoke this credit card on file by submitting a written request to the address at the top of this form. A new form must be submitted if any information such as credit card expirations or authorized users is amended. Applicants agree to pay the cost for any returned or challenged payments.

_____ **Cardholder Signature**

PHONE: 321-255-7779 FAX: 321-255-7774 WEBSITE: www.7sensestherapy.com



NOTICE OF PRIVACY PRACTICES/HIPAA FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a 'patient's rights' section describing your rights under the law. You ascertain by your signature below that you fully understand your rights as a patient.

The HIPAA (Health Insurance Portability and Accountability Act) Law of 1996 allows our practice to use or disclose protected health information for treatment, payment, or healthcare operations. By signing this form, you fully understand that:

Protected health information may be used or disclosed for evaluation, treatment, payment, or healthcare operations of our practice through any and all secured and/or unsecured methods of transfer.

Our practice reserves the right to change the privacy policy as allowed by law.

Our practice has the right to restrict the use of information, but we do not have to agree to those restrictions.

Our practice will condition receipt of treatment upon execution of this consent.

You have the right to revoke this consent in writing at any time, and all full disclosures will then cease.

SIGNATURE OF PARENT/GUARDIAN: _____

Print Name of Patient: _____

Print Name of Parent/Guardian: _____

Date: _____

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Main concern #1:

Specific example:

Specific example:

Main concern #2:

Specific example:

Specific example

Who is present during main concern:

What is happening during concern:

Where is main concern occurring:

When does main concerns occur most often:

Why is it occurring?
Triggers?:

How does main concern happen:

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7 Senses Kids
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Client Intake Form 2025

Date: _____

Client Name: _____ DOB:_____ School: _____
Grade: _____Diagnosis: _____
Child Enjoys: _____
ALLERGIES: _____

Mother/Guardian: _____ Profession: _____
Employer: _____ Work Hours per Week: _____
Favorite Activity with Child: _____
____Single _____Married _____Divorced

Father/Guardian: _____ Profession: _____
Employer: _____ Work Hours per Week: _____
Favorite Activity with Child: _____

Address: _____
Home Phone: _____ Work: _____ Cell: _____
Email: _____

Has your child had Occupational / Speech Therapy before? _____ Yes _____ No
When: _____
Who may we thank for referring you to our office?: _____

Physician/Pediatrician: _____
Physician Address: _____
Physician Phone: _____ Fax: _____

Pediatric Health History/Development

1. Please describe any significant illnesses/difficulties/traumas during the pregnancy with this child:
   _____
   _____

2. Please check off all that apply to the birth of this child: Home birth _____ Hospital _____
   Epidural _____ Episiotomy _____ Vaginal _____ Forceps _____ C-section _____
   Vacuum _____ Manual Assistance _____ Medications _____

3. Length of Labor: _____
4. Was the baby breastfed? _____ If yes, for how long? _____
5. Has your child received vaccinations YES or NO Complete for their age: _____ Partial: _____
   No vaccinations: _____

6. Age child rolled: _____ Age child talked: _____ Age child crawled: _____
   Age child walked: _____

7. What time does the child go to bed?: _____ How long to they sleep?:_____
   Any concerns with sleeping and the bedtime routine:
   _____
8. What does the child eat?:_____
   Any eating concerns: _____
9. Child's Activity/exercise level: _____Hrs per week:_____
   Do they play any sports?:_____
   Any concerns with movement/activity level?: _____
10. Mental Health concerns?: _____

11. Please describe any falls, stitches, fractures, car accidents, sports injuries or other traumas that your child experienced since birth (include ages and dates):
    _____
    _____
12. Please tell us about any health issues/chronic illnesses that the child has had since birth (include ages/dates): _____
13. Any known food allergies: _____ Special Diet?: _____
14. Please list any medications the child is taking: _____
15. Any supplements?: _____
16. Please list any emotional/social/academic stressors in the child's life.
    _____
17. Main Concern(s) for Child:
    _____
    _____
    _____
18. Family History/What Runs in the Family?:
    _____
    _____
19. Lives with? (siblings?): _____

SPEECH ONLY SECTION:

1. Does your child have difficulty understand things you say to them? (receptive communication)_____

2. Does your child have difficulty using language to communicate to you? (Expressive)_____

3. Does your child have difficulty with certain sounds when speaking? (Articulation)_____

4. Does your child have difficulty using language in social settings? (Pragmatics)_____

Parent/Guardian Signature: _____ Date: _____

We thank you for choosing 7 Senses Kids as your occupational therapy provider. We are so happy to be working with you! Our mission is to provide excellent individualized therapy services to achieve functional skills, increased independence, and future dreams. We work with children of all abilities, so they can gain skills for life!

We have been serving the Brevard Community for 11 years and have over 40+ years of combined pediatric experience and knowledge! Our therapists are kind, caring, energetic, passionate, creative and ready to serve your family! We are also known for our outstanding Animal Assisted Therapy Program with our Certified Facility Dog, Aloha. We received her from Canine Companions for Independence in July of 2020. Please let us know if you are interested in this program at no additional charge.

PHOTO CONSENT/RELEASE:
I consent and authorize 7 Senses Therapy, LLC to take and or display photographs and or videos of my child for training, publication, website and/or social media purposes free of compensation.
_____initial.

Here is what we ask of you in order to keep everyone as safe and healthy as possible.

1. **Please keep your child home if they have a fever or are feeling unwell. We are happy to reschedule them.**
2. **Please have your child wear GRIP socks to the studio as they are required. You will be charged 3.99 for a pair from us if needed.**

Please sign for understanding _____ Date: _____

DROP OFF (Optional)
Child's Name: _____
Guardian's Name: _____
Guardian's Cell: _____ Home phone: _____
Emergency Contact: _____ Em. Phone: _____

***Please arrive 5 minutes before the end of your child's session for a recap with your therapist. If you arrive later, we apologize, but we are not able to meet to talk, as we usually have another client following your child's session. The late pick up fee is as follows: $5.00 after the first 5 minutes and then $1.00 per minute afterwards. We appreciate your understanding and thank you for helping our studio run as smoothly as possible.**

Liability Release:I, the undersigned parent or legal guardian, release 7 Senses Therapy, LLC (7 Senses Kids) or any other person acting on their behalf, from liability for any bodily injury sustained and loss or damage of any personal article while on the premises or participating in any activity at 7 Senses therapy, LLC. I also permit 7 Senses Therapy, LLC to seek medical treatment as deemed appropriate through EMS/911 and/or local hospitals if necessary when the undersigned parent or legal guardian is not present.

Guardian Signature _____ Date: _____

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PARENT QUESTIONNAIRE SPEECH AND LANGUAGE THERAPY

Today's Date:
Child's Name:
Date of Birth:
Medical or Developmental Diagnoses:
School Diagnoses: Language(s) Spoken at Home:

Caregiver's Name:

Relationship to Patient:

Caregiver's Name:

Relationship to Patient: Brothers/Sisters:

Name:
Age:
Grade:

Name:
Age:
Grade:

Name:
Age:
Grade:

Who currently lives in the home? (including foster children and those living part time with family):
Who is your child's primary caregiver? _____

REASON FOR REFERRAL Who referred you to 7 Senses Kids?

What are your main concerns about your child's speech and language skills?

When did you first become concerned with your child's speech and language skills?

What would you like your child to be doing 6 months from now?

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SPEECH AND LANGUAGE DEVELOPMENT

How often does your child use the following ways to communicate?
1 word Never Rarely Occasionally Frequently
2 word phrases Never Rarely Occasionally Frequently
3 or more word sentences Never Rarely Occasionally Frequently

Gestures Never Rarely Occasionally Frequently

Signs Never Rarely Occasionally Frequently

Communication Device Never Rarely Occasionally Frequently

Does your child have a communication device? Yes No If yes, what type of device does your child use? _____

Does your child respond to his/her name? Yes No

Does your child try to get you to notice interesting objects? Yes No

When you point to a toy across the room, does your child look at it? Yes No

Does your child engage in pretend play with toys (ex. feed a doll) Yes No

Does your child play well with other children? Yes No If yes, what ages?
_____

Do you have concerns about your child stuttering? Yes No If yes, when did the stuttering begin?
_____

Has anything helped decrease your child's stuttering? _____
_____

Does your child seem to be aware of the stuttering? Yes No

Do you have concerns about your child's voice (i.e. soft, hoarse, loud)? Yes No

THERAPY Has your child's speech-language development been evaluated before: Yes No
If yes, when: _____ where (school, clinic, etc): _____
Results: _____
Is your child currently receiving: Speech Therapy: Yes No If yes, how often: _____
where: _____

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Occupational Therapy: Yes No If yes, how often: _____ where: _____

Physical Therapy: Yes No If yes, how often: _____ where: _____

Additional comments: _____
_____

EDUCATION Does your child attend daycare? Yes No If yes, how often: _____ where: _____

Where does your child go to school? _____
School District: _____
Grade: _____
Does your child have an IFSP, IEP or 504 plan? Yes No

MEDICAL HISTORY Were there any problems during your pregnancy? Yes No

Were there any problems during your child's birth? Yes No

Has your child had any significant illnesses, injuries, and/or hospitalizations? Yes No

If yes to any of the above, please describe:
List any medications currently being taken:
Does your child have any allergies (medicine, food, environment)? Yes No
If yes, please list: _____
Has your child been evaluated by an ear, nose and throat (ENT) doctor? Yes No
If yes, why: _____
Does your child have a history of frequent ear infections? Yes No If yes, please describe: _____
Does your child have ear (PE) tubes? Yes No
Has your child's hearing been tested? Yes No
If yes, when: _____ where (school, clinic, etc): _____
Results: _____
Has your child been seen by a psychologist? Yes No If yes, when: _____ where (school, clinic, etc): _____
Results: _____

Does your child have behaviors that: Impact learning/school Yes No

Interfere with social interactions Yes No
Are aggressive towards self Yes No
Are aggressive towards other people Yes No
Are aggressive towards objects/property Yes No If yes to any of the above, please explain:

Does your child have a behavior plan? Yes No If yes, please explain:

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FEEDING DEVELOPMENT Is your child's weight gain a concern? Yes No
If yes, please explain:
Does or did your child have difficulty starting to eat solid foods? Yes No
Does or did your child have difficulty swallowing? Yes No
Does your child allow his/her teeth to be brushed? Yes No
Will your child allow you to touch his/her mouth on the inside? Yes No

FAMILY HISTORY Does your child have family members with any of the following concerns:
Speech or Language Yes No If yes, who? _____
Stuttering Yes No If yes, who? _____
Hearing Loss Yes No If yes, who? _____
Cleft Palate Yes No If yes, who? _____
Autism Spectrum Yes No If yes, who? _____
Developmental Delay Yes No If yes, who? _____
Reading or Learning Disability Yes No If yes, who? _____
ADHD Yes No If yes, who? _____
Additional comments or concerns: _____
_____

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WAIVER AND RELEASE OF LIABILITY

IN CONSIDERATION OF the risk of injury that exists while participating in THERAPY SERVICES, CLASSES, TUTORING, and/or OPEN GYM TIME (hereinafter the "Activity"); and

IN CONSIDERATION OF my desire to participate in said Activity and being given the right to participate in same;

I HEREBY, for myself, my heirs, executors, administrators, assigns, or personal representatives (hereinafter collectively, "Releasor," "I" or "me", which terms shall also include Releasor's parents or guardian if Releasor is under 18 years of age), knowingly and voluntarily enter into this WAIVER AND RELEASE OF LIABILITY and hereby waive any and all rights, claims or causes of action of any kind arising out of my participation in the Activity; and

I HEREBY release and forever discharge 7 SENSES THERAPY, LLC, located at 2261 Town Center Ave #109, Melbourne, Florida 32940, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns (collectively "Releasees"), from any physical or psychological injury that I may suffer as a direct result of my participation in the aforementioned Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO: PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL TO AND FROM THE ACTIVITY, OR FROM CONDITIONS AT THE ACTIVITY LOCATION(S). NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN AND UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY.

I FURTHER AGREE to indemnify, defend and hold harmless the Releasees against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs.

I FURTHER ACKNOWLEDGE that Releasees are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Releasees. In the event that I should require medical care or treatment, I authorize 7 Senses Therapy, LLC to provide all emergency medical care deemed

necessary, including but not limited to, first aid, CPR, the use of AEDs, emergency medical transport, and sharing of medical information with medical personnel. I further agree to assume all costs involved and agree to be financially

responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

I FURTHER ACKNOWLEDGE that this Activity may involve a test of a person's physical and mental limits and may carry with it the potential for death, serious injury, and property loss. I agree not to participate in the Activity unless I am medically able and properly trained, and I agree to abide by the decision of the 7 Senses Therapy, LLC official or agent, regarding my approval to participate in the Activity.

I HEREBY ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE 7 Senses Therapy, LLC AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST 7 Senses Therapy, LLC FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for ordinary negligence, this release is also for such negligence on the part of 7 Senses Therapy, LLC, its agents, and employees.

I agree that this Release shall be governed for all purposes by Florida law, without regard to any conflict of law principles. This Release supersedes any and all previous oral or written promises or other agreements.

In the event that any damage to equipment or facilities occurs as a result of my or my family's or my agent's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any such actions of neglect or recklessness.

THIS WAIVER AND RELEASE OF LIABILITY SHALL REMAIN IN EFFECT FOR THE DURATION OF MY PARTICIPATION IN THE ACTIVITY, DURING THIS INITIAL AND ALL SUBSEQUENT EVENTS OF PARTICIPATION.

THIS AGREEMENT was entered into at arm's-length, without duress or coercion, and is to be interpreted as an agreement between two parties of equal bargaining strength. Both Participant, _____ and 7 Senses Therapy, LLC agree that this agreement is clear and unambiguous as to its terms, and that no other evidence shall be used or admitted to alter or explain the terms of this agreement, but that it will be interpreted based on the language in accordance with the purposes for which it is entered into.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

In the event of an emergency, please contact the following person(s) in the order presented: **Emergency**

Contact **Contact Relationship** **Contact Telephone**

I, THE UNDERSIGNED PARTICIPANT, AFFIRM THAT I AM OF THE AGE OF 18 YEARS OR OLDER, AND THAT I AM FREELY SIGNING THIS AGREEMENT. I CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I FULLY UNDERSTAND ITS CONTENT AND THAT THIS RELEASE CANNOT BE MODIFIED ORALLY. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND THAT I AM SIGNING IT OF MY OWN FREE WILL.

Participant's Name:

Participant's Address:

Signature:

Date:

PARENT / GUARDIAN WAIVER FOR MINORS

In the event that the participant is under the age of consent (18 years of age), then this release must be signed by a parent or guardian, as follows:

I HEREBY CERTIFY that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this individual.

Parent / Guardian Name:

Relationship to Minor:

Signature:

Date: