

VCAT TREATMENT CENTER

Neuro Sense Herbal Supplement/Products Disclosure Form

I, _____, would like to disclose the voluntary use of the Neuro Sense Herbal Supplements/Products. I understand and am aware of the benefits and possible side effects of Neuro Sense products. I am also aware and agree of not using the information I have been given about the Neuro Sense supplements/ products to self-diagnosis and or for treating a health problem or disease. Furthermore, I understand and agree of not exceeding the recommended doses and to stop using Neuro Sense supplements/products and contact my health-care provider immediately if I suspect any side effects and or any medical problems.

| Date | Recommended Doses | Date/Consultation |
|------|-------------------|-------------------|
| | Capsules | |

Signature

Date

Email Address