RDT Advanced Wellness Center

Hearing Protection Requirement Waiver

Name:_____ DOB: _____

I, _____, have been informed that it is recommended to wear ear plugs during TMS therapy treatment to protect my hearing. I choose to not wear hearing protection and will hold harmless, *RDT Group*, its employees, physicians, affiliates, and agents in the event of an adverse effect due to my decision. I understand that it is my choice to not wear hearing protection and I must sign this waiver whether I choose to wear or decline ear plugs.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date