HOLD HARMLESS AGREEMENT

To whom it may concern:

I voluntarily consent to be ministered by Agape Christian Counseling, LLC. I understand that some of the procedures used to give spiritual and emotional help may or may not be clinically demonstrated as guaranteeing either short term or long-term results. I accept this ministry fully and completely and do not hold any one responsible for ANY outcome that may arise as a result of this ministry. I do not hold Agape Christian Counseling, LLC responsible for any further or additional care that I may need in the future. I take full responsibility for my life, health and well-being now and in the days to come.

I am voluntarily accepting this offer of ministry and acknowledge that I understand that I am free to terminate my participation at any time for any reason. I understand that I must take full responsibility for any and all consequences for any spiritual intervention done for or on my behalf. I also understand that once I end this ministry, I accept full responsibility for any choices I make that may be detrimental or harmful to me. I also accept full responsibility for all aftercare and follow-up ministry since this ministry opportunity is limited to this particular time frame and does not provide for any promise of future ministry.

I also fully understand that this ministry is being offered on a paid basis for services rendered. If I choose to contribute any money to this ministry over and above the services I receive it will be viewed as a donation and as a token of my appreciation. I acknowledge that Agape Christian Counseling, LLC is not a 501(c)3 non-profit entity, and donations may not be deductible for tax purposes.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print above name clearly.)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

Witnessed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR PAYMENT MUST BE RECEIVED IN ADVANCE ALONG WITH THIS FORM AND A COPY OF A PHOTO ID TO VERIFY YOUR SIGNATURE.

Thank you