DUPLECHAIN INNOVATION WELLNESS CLINIC

NATURAL PRODUCT TESTING WAIVER, RELEASE OF LIABILITY, NONDISCLOSURE & HOLD HARMLESS AGREEMENT

D. Duplechain and Staff | Duplechain Innovation Wellness Clinic

PARTICIPANT INFORMATION

Participant Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Address: _____

PRODUCT BEING TESTED

Product Name: _____

Product Type/Form: _____

Date Provided: _____

Testing Instructions Provided: ☐ Yes ☐ No

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1. PURPOSE OF PRODUCT TESTING

I understand that I am voluntarily being given an opportunity to test and provide feedback regarding a **natural, botanical, herbal, nutritional, or other wellness product** developed, formulated, supplied, or provided by **D. Duplechain, Duplechain Innovation Wellness Clinic, and/or their staff, representatives, contractors, or affiliates** (“Clinic”).

I understand that the Product may be a new, prototype, experimental, reformulated, or otherwise not yet commercially established product.

The purpose of testing is to obtain information regarding the Product, including, but not limited to, user experience, tolerability, taste, texture, convenience, perceived effects, and other feedback that may assist with future product development.

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2. EXPERIMENTAL/NATURAL PRODUCT ACKNOWLEDGMENT

I understand that natural and herbal products may affect individuals differently.

I acknowledge that the Product may contain herbs, botanicals, plant extracts, minerals, nutrients, or other naturally derived ingredients and that the Product may have potential risks, side effects, interactions, sensitivities, or allergic reactions.

I understand that natural or herbal does **not** necessarily mean risk-free.

I understand that the Product may not have been subjected to the same testing, review, or evaluation as an established commercial product and may be undergoing development, evaluation, or quality testing.

I voluntarily choose to participate despite these potential risks.

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3. PARTICIPANT RESPONSIBILITY

I agree to:

- Follow the instructions provided by the Clinic concerning the Product.
- Use only the amount and frequency instructed.
- Truthfully report relevant information requested by the Clinic concerning my experience with the Product.

- Immediately notify the Clinic of any unexpected reaction, discomfort, suspected allergy, or other concern.
- Stop using the Product if I experience a concerning or potentially serious reaction and seek appropriate medical attention when necessary.
- Inform the Clinic of known allergies, sensitivities, medications, supplements, pregnancy, breastfeeding, or other relevant circumstances that may reasonably affect my ability to safely participate.

I understand that I am responsible for providing truthful and complete information.

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4. MEDICAL ACKNOWLEDGMENT

I understand that participation in Product testing is voluntary and that the Product is not being represented as a substitute for emergency medical care or any treatment prescribed by my licensed medical provider.

I understand that the Clinic may provide general wellness information concerning the Product, but I remain responsible for discussing the use of any Product with my physician, pharmacist, or other qualified healthcare professional when appropriate.

I understand that I should not discontinue, reduce, or change prescribed medication solely because I am participating in this Product Test unless directed by my licensed healthcare provider.

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5. ASSUMPTION OF RISK

I understand that participation in natural-product testing involves potential risks, including but not limited to:

- Allergic or sensitivity reactions;
- Gastrointestinal discomfort;
- Changes in appetite, digestion, bowel movements, sleep, energy, or other bodily responses;
- Interactions with medications, supplements, herbs, or other substances;
- Unexpected or unknown reactions;
- Risks associated with ingredients that may not yet be fully characterized for my individual circumstances; and
- Other risks that may not currently be known.

I voluntarily assume the risks associated with participating in the Product Test, to the fullest extent permitted by applicable law.

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6. RELEASE OF LIABILITY

To the fullest extent permitted by applicable law, I, for myself and my heirs, representatives, estate, successors, and assigns, hereby release and discharge **D. Duplechain, Duplechain Innovation Wellness Clinic, and their owners, officers, employees, staff, contractors, representatives, agents, and affiliates** ("Released Parties") from claims, demands, liabilities, damages, costs, or expenses arising out of or relating to my voluntary participation in the Product Test, including the use or attempted use of the Product, except to the extent such release is prohibited by law.

This release applies to injuries, illness, allergic reactions, property damage, or other losses that may arise in connection with participation in the Product Test, to the extent permitted by law.

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7. HOLD HARMLESS & INDEMNIFICATION

To the fullest extent permitted by applicable law, I agree to hold harmless and indemnify the Released Parties from claims, damages, liabilities, costs, and reasonable expenses arising from my participation in the Product Test or my misuse, unauthorized use, or failure to follow provided instructions concerning the Product, except where such indemnification is prohibited by law.

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8. CONFIDENTIALITY & NONDISCLOSURE

I understand that the Product, formulation information, ingredients or ingredient combinations, testing procedures, development information, research information, business information, and non-public Product information may be confidential.

I agree not to disclose, photograph, reproduce, distribute, sell, copy, reverse engineer, or publicly share confidential Product information without written permission from the Clinic.

This includes posting confidential Product information, photographs, formulations, testing information, or unreleased Product details on social media or other public platforms.

This confidentiality obligation does not apply to information that is lawfully available to the public through no violation of this Agreement or information that I am legally required to disclose.

9. PRODUCT FEEDBACK

I understand that the Clinic may ask me to provide written or verbal feedback concerning my experience with the Product.

I voluntarily authorize the Clinic to use my feedback for legitimate business, educational, research, quality-improvement, formulation, development, and marketing purposes, subject to applicable law.

☐ **I authorize the Clinic to use my feedback anonymously.**

☐ **I authorize and give permission to the Clinic to use my name and/or testimonial**

I understand that I will not receive compensation for ordinary feedback.

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10. NO GUARANTEE

I understand that no particular result, benefit, outcome, or response from the Product has been promised or guaranteed.

I understand that individual responses may vary.

I understand that Product testing may result in changes to the Product, formulation, ingredients, dosage instructions, packaging, labeling, or availability.

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11. VOLUNTARY PARTICIPATION

I understand that participation is completely voluntary.

I may stop participating in the Product Test at any time by notifying the Clinic and discontinuing use of the Product, subject to any reasonable instructions provided for safely discontinuing participation.

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12. EMERGENCY/ADVERSE REACTION ACKNOWLEDGMENT

I understand that if I experience a severe, unexpected, or potentially life-threatening reaction, I should immediately seek appropriate emergency medical attention by contacting **911 or the appropriate emergency medical service**.

I understand that the Clinic is not an emergency medical service.

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13. ENTIRE AGREEMENT

I understand that this Agreement represents the terms applicable to my participation in the Product Test and supersedes prior oral statements concerning the matters addressed herein, except for any separate written agreement signed by the parties.

If any provision of this Agreement is determined to be unenforceable, the remaining provisions shall remain in effect to the fullest extent permitted by law.

This Agreement shall be interpreted under applicable law.

PARTICIPANT ACKNOWLEDGMENT & SIGNATURE

By signing below, I acknowledge that:

☐ I am at least **18 years old**.

☐ I have read and understand this Agreement.

☐ I have had an opportunity to ask questions before participating.

☐ I understand that the Product may be new, experimental, prototype, or otherwise under development.

☐ I understand that natural and herbal products may carry risks and may affect individuals differently.

☐ I voluntarily choose to participate in the Product Test.

☐ I agree to follow the Product instructions provided to me.

☐ I understand that I am responsible for informing the Clinic of relevant allergies, medications, supplements, pregnancy, breastfeeding, or other circumstances that may affect my participation.

☐ I understand the confidentiality requirements contained in this Agreement.

☐ I understand that I am signing this Agreement voluntarily.

Participant Printed Name: _____

Participant Signature: _____

Date: _____

CLINIC REPRESENTATIVE

D. Duplechain / Authorized Clinic Representative

Signature: _____

Date: _____

Product/Batch or Test ID: _____

FOR CLINIC USE ONLY

Product Provided: _____

Quantity: _____

Instructions Given: _____

Special Instructions/Notes: _____

Participant Questions/Concerns: _____