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CONSENT FORM

I, _____ (print name) consent to treatment for myself (or my minor child) _____ (print name), and understand that the services provided by the practitioner is intended to enhance relaxation and increase communication within my body.

I understand that these services are not a substitute for medical treatment or medications. I am aware that diagnosis is not given and medication is not prescribed. I agree to continue to have regular medical check-ups as part of my overall health care plan.

I understand that participation is voluntary and that at all times I may choose to end my participation. I understand that I may experience 'healing reactions' during the 24 to 48 hours following the services provided.

I understand that any information exchanged during any session is educational in nature and is to be used at my own discretion. I also understand that any information imparted during these sessions is strictly confidential in nature and will not be shared with anyone without my written permission. I do, however, give the practitioner consent to use my case history and results without using my name. I understand that only the practitioner will have access to information in my file to enhance my healing.

I understand that by providing this informed consent I am assuming full responsibility for my services and I hold harmless both the practitioner and the facility/location where the services are provided.

I agree to the terms and conditions set out by this consent form and certify that the above information is true and correct. I agree to pay for distance sessions, should I request them.

_____ SIGNATURE

_____ WITNESS SIGNATURE

_____ DATE

_____ WITNESS PRINT NAME