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Welcome!

Distant Energy Healing/Craniosacral Therapy Intake and Consent Forms

Please complete the following information.

Name:_____ Telephone: _____
Address:_____
Email:_____
Date of Birth:_____
Would you like your email to be added to my newsletter for updates and educational/inspirational messages? **Y/N**
Referral source:_____
Emergency Contact and Phone:
_____

If needed, may we share your information with your physician for coordination of care? **Y/N**
Please provide your Physician/Clinic Address and Phone Number:
_____

Have you ever had an in-person Reiki and/or Craniosacral therapy session before? **Y/N**
Have you ever had a distant Reiki and/or Craniosacral therapy session before? **Y/N**
Do you have a particular are of concern (physical, emotional, mental, spiritual)?
_____
_____
What goals would you most like to achieve?
_____
_____

Are your health-related goals part of a legal case? Y/N

Payment and Cancellation Policy

All services are rendered on a fee for service basis. I am sorry that I do not take health insurance or Medicare. You are expected to pay for services at time of treatment. Full payment is due if you cancel a scheduled session with less than 24 hours' notice.
Client
Signature_____Date_____

Client Confidentiality/HIPPA Policy

As a practitioner, I am dedicated to providing you with the best of care and protecting your privacy. I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to conduct, plan, and direct treatment and follow-up among healthcare providers who may be involved in that treatment directly or indirectly as needed. I am aware that all information exchanged through verbal, written, email, and voicemail shall be confidential and the relationship between client and practitioner shall be respected. Confidentially between practitioner and client shall be maintained unless unlawful issues or intent to harm another or oneself dictate otherwise. This office will not use or disclose information about you for the purposes of marketing and will not sell your information to unrelated companies.

Patient Rights:
Upon written request you have the right to access, review or receive copies of your healthcare records. You have the right to provide a written request of how your private information is used or disclosed to carry out treatment, payment, or healthcare operations.

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Practices for healthcare services.

Client
Signature_____Date_____

DISTANT ENERGY HEALING MODALITIES
INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of energy healing modalities and treatments, including distant Reiki, distant craniosacral therapy, guided meditation/visualization instruction, coaching.
I will immediately notify Deborah A Rogers of any unanticipated or unpleasant effects associated with any of the energy modalities applied. **I** have been informed that energy medicine is a generally safe method of treatment, but that shifts in energy occur and may create some physical, emotional or spiritual effects which may include feeling warmth or cold sensations, physical tingling, feeling lighter energetically, feeling more balanced and centered, mild fatigue, thirst, shifts of perception, etc. I do not expect the energy practitioner to be able to anticipate and explain all possible consequences of energy treatment, and I wish to rely on the energy practitioner to exercise judgment during the course of treatment which the energy practitioner exercises a best and highest interest for healing, based upon the facts then known and for my best interest and highest good. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of energy medicine and intuitive energy healing and other energy modalities, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of my energy treatments for my present condition and for any future conditions(s) for which I seek any energy healing modalities.

Client Signature: _____ Date:_____

(Or Patient Representative):_____

Distant Energy Healing
Liability Waiver and Release

I, _____, take personal responsibility for my well-being and with respect for myself I gratefully accept control of my choices. My heirs, guardians, legal representatives, and I hereby and forever release, waive, and discharge any claims against, Deborah A Rogers, Holistic Occupational Therapist. I take full responsibility and am responsible for all liability for loss or injury incurred while in association with or applying energy techniques and information learned from Deborah Rogers, OTR/L and/or any of their associates or affiliates.

I have carefully read this agreement and fully understand its content. I am aware that this is a waiver and release of potential liability and a contract between the above noted parties and myself. I understand that this contract is binding and acknowledge that I am signing this of my own free will.

Client Signature:_____ Date:_____

Printed Name:_____

Thank you for taking the time to complete these forms.