

Client Information and Consent for Treatment

for: _____

I understand that:

- ✓ Healing Touch and Reiki are both non-invasive hands-on holistic Energy Therapy treatment modalities that focus on clearing and balancing the human energy system. This treatment supports the body's natural self-healing ability.
- ✓ An assessment will be conducted to determine the present condition of my energy system and my general physical, mental, and emotional health, and that this information will be shared with me.
- ✓ Any treatment or suggestions given will be intended to assist my body's natural ability to achieve a balanced state and to promote my natural self-healing of body, mind, emotions, and spirit.
- ✓ The goals of my treatment will be mutually identified with Sue and I will have input into my goal and intention setting.
- ✓ Sue practices within her scope of practice for Healing Touch as a Healing Touch Certified Practitioner and Reiki as a Certified Reiki Master. Sue does not diagnose conditions, prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional. **Note:** Copies of the *Healing Touch Program Statement of Scope of Practice & Code of Ethics* are provided upon request and can be found at <http://www.healingtouchprogram.com/ethics/index.shtml>
- ✓ This treatment is not meant to replace medical care or treatment by established medical practices, but is meant to integrate with, and complement them.
- ✓ There are no guarantees as to the results of treatment that are expressed or implied.
- ✓ A state of extremely deep relaxation is often experienced with energy therapy and this can sometimes result in deep emotional, physical, or mental shifts, releases, or realizations.
- ✓ I will be asked to consent to Sue lightly placing her hands on my body during the treatment.

I agree to:

- ✓ Ask any questions at any time about anything I do not understand or want more information about.
- ✓ Express any concern or discomfort that I have during the treatment, or to make any request that I want to.
- ✓ Consider suggestions that Sue may raise concerning referrals to other health care practitioners.
- ✓ Take full responsibility for my own wellbeing and health care.
- ✓ Present questions or concerns that I have regarding the treatment.
- ✓ Not hold Sue responsible for my physical condition, mental or emotional state, or my personal wellbeing.
- ✓ Give consent to **Sue Walker (HTCP, CRM)** to conduct a treatment to clear and balance my energy system.

Continued on back

Sue Walker ∞ **Wellness Within**^{LLC}

Healing Touch Certified Practitioner (HTCP) ∞ Certified Reiki Master (CRM)

970.690.8865 ∞ www.WellnessWithinUs.com ∞ email: Sue@WellnessWithinUs.com

Confidentiality

- ✓ Any exchanges and experiences during treatment sessions will remain confidential except under circumstances detailed in *Colorado Statutes 12-43-218. Disclosure of confidential communications* (provided upon your request).
- ✓ Information will only be released to agencies or individuals with your signed authorization, except in the legal situations noted directly above.
- ✓ Client files are maintained in strict confidence in accordance with Colorado State laws and the professional standards defined in the *Healing Touch Program Code of Ethics* and *Statement of Scope of Practice*. No confidential information is stored electronically therefore HIPPA regulations do not apply.

Fees and payment

- ✓ I agree to pay the standard fee of \$55 per 60 minute treatment in Sue's office unless another payment arrangement has been agreed upon with Sue prior to the treatment. Other arrangement:
- ✓ I understand that Sue honors a sliding scale fee and I agree to negotiate treatment fees if needed.
- ✓ I agree to provide payment at the treatment appointment by check or cash or by PayPal to Sue@WellnessWithinUs.com prior to the treatment.
- ✓ I understand that Sue does not file insurance claims but will provide me with a receipt upon request.
- ✓ I agree to pay a fee of \$35 to Sue Walker if my check for payment is returned for nonsufficient funds or for any other reason.

Cancellation Policy

I understand I will be charged the standard or negotiated treatment fee for cancellations made with less than 24 hours notice, or for not being present for a scheduled appointment. Note that exceptions will be made for unforeseen emergency situations.

Client or Legal Guardian Signature _____

Date _____

Client name printed _____

Legal Guardian name printed _____

06.09.10

Sue Walker ☯ **Wellness Within**^{LLC}

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