

Client Informed Consent for _____

I understand that:

- ✓ Healing Touch and Reiki are both non-invasive hands-on holistic Energy Therapy modalities that focus on clearing and balancing the human energy system, which in turn supports the body's natural self-healing ability.
- ✓ A personal interview will be conducted with me to allow the practitioner, Sue Walker, to personally assess 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 interventions or suggestions given by Sue will be intended to assist my body's natural ability to achieve a balanced energetic 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 as part of the treatment process and I will have input in my goal setting.
- ✓ Sue practices within her scope of practice for Healing Touch and Reiki Energy Therapy and 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 complement and integrate with them.
- ✓ There are no guarantees as to the results of treatment that are expressed or implied by Sue.
- ✓ I will not hold Sue responsible for my physical condition, mental or emotional state, healing, or personal wellbeing.
- ✓ 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.
- ✓ Contact Sue with questions or concerns that I have regarding the treatment.
- ✓ 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 your treatment, as well as any information you disclose during your treatment will remain confidential except under circumstances detailed in *Colorado Statutes 12-43-218. Disclosure of confidential communications* (provided upon your request).
- ✓ Information may only be released to individuals or agencies 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 understand that payment will be made at the time of service by check or cash at the time of the treatment, 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 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 _____

01.01.10

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