

HEALING TOUCH CONSENT FORM

I _____ have received information and understand that Healing Touch is a gentle, complementary energy based approach to health and healing that can assist my body in its natural ability to heal. I fully acknowledge and understand that this is accomplished through the use of contact and/or noncontact touch.

It has been explained to me, that Healing Touch is a complementary therapy not intended to replace any currently prescribed medical treatments as ordered by my physicians nor any other medical care I have I may be advised to seek by them.

I have been informed that my Healing Touch practitioner will neither diagnose any medical condition nor prescribe for any condition that I might have nor does she make any specific claims regarding results from the Healing Touch sessions that I receive.

I have been encouraged to consult a licensed medical practitioner for any physical or mental complaints I may have.

Some of the indications for a Healing Touch session include, but are not limited to:

- Reduction in pain, anxiety and stress
- Decrease in nausea
- Preparation for medical treatment and procedures and to manage side-effects
- Support during chemotherapy
- Supports the body's natural healing process and sense of well-being
- Facilitation of wound healing
- Emotional-Mental-Spiritual support

I have been informed that all client information and records are treated in a confidential manner. My experiences during these sessions are confidential subject to the usual exceptions governed by State or federal laws and regulations.

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless my Healing Touch Practitioner, Inés Almeida, and Adrienne Beaupré & Assoc. LLC from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

My questions have been answered to my satisfaction regarding my Healing Touch Practitioner's background, Healing Touch, and what I might expect from this session.

I give my consent to receive Healing Touch from Inés Almeida.

Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____

Cancellation Policy: We require a minimum of 24hrs notice for all cancellations to avoid full service charge. Your appointment is important to us.

Signed: _____ Date: _____