



## HOLISTIC ENERGY SERVICES INTAKE FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

May we contact you via email regarding your care?      Y      N      May We Text?      Y      N

Today's Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

### INFORMED CONSENT FOR TREATMENT AND CARE

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

I hereby request and consent to holistic guidance & related services including but not limited to: Reiki, hands on healing touch, intuitive readings, spiritual guidance, shamanic healing, and other procedures for energy clearing in person and/or virtually. I understand that this work is not medical treatment and is not intended to treat, diagnose, or cure illness/disease and is not a substitute for mental health therapy.

I understand the above techniques used will produce content that will vary from person to person and may include some or all the techniques during one session. I understand these techniques may include hands on healing touch of the body, essential oil use, burning of herbs/plants, discussion, emotional release, tingling, hot, cold sensations, relaxation, etc.

It is my responsibility to inform the Practitioner if I have a condition that would be impacted during or might impact the session. I do not expect the Practitioner to be able to anticipate and explain all possible risks and complications. I wish to rely on the Practitioner's judgment during the course of my session and request that he/she does what he/she feels at the time is in my best interest, based upon the facts then known.

All payments are due at time of service by cash or check, (payable to Abel Chiropractic, PC) or prepaid via credit card. You will be invoiced for the full value of your session if you cancel within 4 hours. (Exemptions apply at the discretion of the Practitioner.)

### DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read [ ] or have had read to me [ ] the above explanation of care and related sessions. I have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing these services and have decided that it is in my best interest to undergo with holistic guidance & related services.

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Signature of Practitioner