Emotional Blueprint Coaching and Intuitive Reflexology

Informed Consent to Treatment

Name: _____ ◯Female ◯Male Birth Date: _____

I understand that Emotional Blueprint Coaching and Intuitive Reflexology is a gentle, hands-on energy technique.

I understand that the practitioner does not diagnose conditions nor does she prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional.

I understand that Emotional Blueprint Coaching and Intuitive Reflexology does not take the place of medical care. It is recommended that I see a licensed physician or licensed health care professional for any physical or psychological ailment I may have.

I understand that Emotional Blueprint Coaching and Intuitive Reflexology can complement any medical or psychological care I may be receiving.

I acknowledge that it will usually require more than one session in order to facilitate the body's ability to heal itself.

Emotional Blueprint Coaching and Intuitive Reflexology is a holistic health treatment to encourage the release of emotions from the body, bring relaxation and to facilitate healing.

Emotional Blueprint Coaching and Intuitive Reflexology is practiced while the client is fully clothed, on a massage table. I will be required to only remove my socks and footwear to allow the practitioner to use their hands to work on my feet.

If at any time I feel discomfort, I will inform the practitioner immediately and can stop the session at any time.

I understand that during the session I may be asked to practice meditation and / or visualisation techniques and that it is my choice whether I choose to do these. I will inform the practitioner if I am not comfortable with these techniques.

I am / am not (circle one) pregnant at this time. I will inform the practitioner immediately if this or any other aspect of my health changes during the course of my treatments.

I may withdraw this consent at any time and will inform the practitioner immediately if I do so.

I confirm that I have read and understand the above.

I give permission to the practitioner to perform such services as outlined above, and state that I have disclosed any information (health or otherwise) that may alter the effectiveness of services offered.

Patient Name _____ Guardian Name: _____

Patient / Guardian Signature_____ Date: _____

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