

Informed Consent

I hereby consent to Biodynamic Craniosacral Therapy for the noted purposes including such assessments, examinations and techniques, which may be recommended by my therapist, Ruth Hill.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that Biodynamic Craniosacral Therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical and life conditions. I have disclosed to the therapist all of those medical and life conditions affecting me. It is my responsibility to keep the therapist updated on my medical history and any life conditions that may affect my treatment. The information I have provided is true and complete to the best of my knowledge.

I authorize my Craniosacral Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

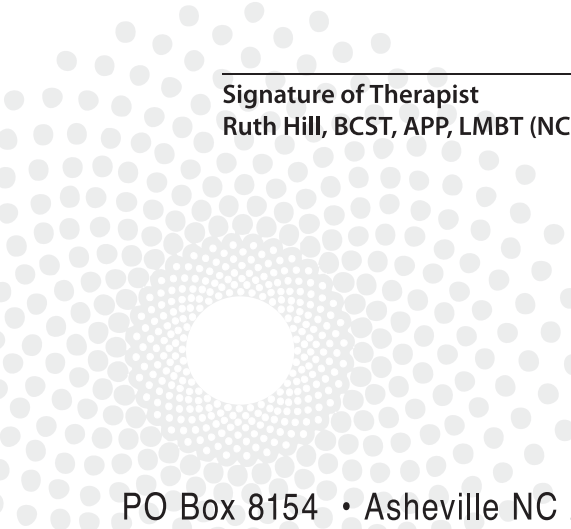
I understand there will be a missed appointment charge as the day and time have been set aside specifically for me. I understand that without a 24-hour notice of cancellation, except in cases of illness, emergency or inclement weather, full payment will be due.

Signature of Client

Date

Signature of Therapist
Ruth Hill, BCST, APP, LMBT (NC1469)

Date



Ruth Hill biodynamic craniosacral therapy

BCST LMBT (NC 1469)