Dancing With Life Bodywork

3256 Millgrove Street, Victoria, BC V8Z 3V5

Client Consent Form

Please take the time to carefully read the following information and sign where indicated.

I understand that the services provided at **Dancing with Life Bodywork** helps identify energetic imbalances and are for the purposes of relaxation, stress reduction, enhancing wellness, and improving awareness of my body and consciousness. I fully understand that **Craniosacral Therapy** should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician (MD), naturopathic doctor, chiropractor or other qualified medical specialist for any mental or physical ailment for which I may need diagnosis and treatment. I understand that the attending practitioner is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe for, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I have solicited the attending practitioner's services in good faith, following the dictates of my own conscience, which allows me to select what I understand is the most beneficial for my health. I am fully aware and release the practitioner to perform the protocols of their modality to compliment my body's natural potential to heal. Any advice or suggestions offered by the practitioner is purely based on personal knowledge, training, and life experience.

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that adjustments can be made to my level of comfort. I affirm that I have stated all my known medical conditions, and answered all questions honestly and fully. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the part of the practitioner or Dancing With Life Bodywork should I fail to do so. I also understand that any sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the scheduled appointment.

By signing below I am assured of the strictest confidentiality regarding the information provided in the client consultation form and any subsequent discussion of notes (except where I have separately agreed in writing to the sharing of information with other healthcare providers). I have read and understand all parts of this document, and that I had the opportunity to ask any questions with regard to Craniosacral Therapy. I hereby affirm: **I am not here for medical diagnostic or treatment procedures, and I am here on this and any subsequent visit solely on my own behalf or that of a dependent. I acknowledge that I am financially responsible to cover the cost of a session if I give less than 24 hours notice to cancel.**

Please Print Name _____

Client Signature _____ **Date:** _____

Consent to treatment of a minor: By my signature below, I hereby declare that I am the parent or legal guardian of my child or dependent and authorize Cindy Thompson, BSN, CCT to administer Craniosacral Therapy to the above named minor.

Name of dependent (if signing for a minor) _____

Signature of Parent or Guardian _____ **Date:** _____

Signature of Practitioner _____ **Date:** _____