Phoebe Allwell BHS
Energy Medicine Therapist
Australia office: 0418 296 107
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www.neuraltransmissionrepatterning.com

CONFIDENTIALITY & CONSENT FORM FOR TREATMENT

The purpose of this consent form is to explain to you what I can do for you and what you can expect. My belief about healing is that each of us is his or her own healer; that healing comes primarily from within. I can assist you in your healing by doing various kinds of techniques, which will balance your energy and enhance your sense of well-being. Among the techniques that I use are healing by laying on of hands and energy/frequency work, done both with my hands on the body and also through the Energy Consciousness System with surrounds the body. The work can be in person or by long distance via the telephone. I will be able to tell you where energy is blocked in your body and help you to release these blocks.

We may discuss the major stressors in your life, your belief systems, health history, your childhood and other issues that have an influence on your emotional and physical well-being.

These discussions will be kept confidential except:

a) if and to the extent authorized by yourself.
b) as required for my professional supervision where your name remains anonymous, and only to the extent necessary to achieve the purposes of the supervision.
c) when disclosure is required to prevent clear and imminent danger to yourself or others.
d) as required by law.
e) if I am a defendant in a civil, criminal or disciplinary action arising from the client relationship (in which case client confidences may only be disclosed in the course if that action).

At your written request or approval, and according to my capabilities, and good conscience, and professional judgment that I may I consult with your other healers, therapists, physicians and spiritual teachers as appropriate to maximize the benefits to yourself.

I am not a physician and therefore do not diagnose disease or prescribe drugs. I am a Certified Energy Medicine Practioner.

At all times your healing is your responsibility. I am available to be your partner in this process, your committed listener, and your mirror. I do not advise you to discontinue any medical treatment you may be receiving. My work is intended to be in harmony with any other healing work that you undertake, including traditional medicine. Please feel free to discuss our work with your doctor or please let me know if you would like me to discuss any of our sessions with your doctor.

Cancellation Policy:

I prefer to set up a regular schedule to work with you but there is never an obligation to continue treatment. Our first session is 1.5 hours and follow-up treatments are generally one hour in duration. However because of the nature of my work sometimes sessions are longer. If this occurs the treatment fee is in 15minute increments.

If you cancel an appointment please give as much notice as possible. I ask for full payment for the session if you cancel within 24 hours from the session time. If you need to cancel over a weekend, I ask for 48 hours notice of cancellation.

Payment:

When doing in-person treatments in my office I expect payment to be made either by cash, money order or check at the time of treatment. For long distance work via the telephone I expect payment to be made at the time of service via credit card or if by check or money order I expect payment to be received by my office prior to the treatment.

In signing the attached Acknowledgment and Release form you agree that I may work with you in the above-described manner. I make no promises other than those outlined above. Many of my clients experience increased well-being and improvement in their condition. But I cannot promise you these things. I am not aware of any risks or negative side effects associated with these treatments.

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ACKNOWLEDGEMENT AND RELEASE

I hereby acknowledge that I have read the foregoing Confidentiality & Consent for Treatment, am satisfied that I fully understand the nature of the treatments, and freely elect to receive these treatments. I release Phoebe Allwell from any and all claims of malpractice, non-disclosure, or lack of informed consent. I freely assume any and all risks of the treatment whether presently contemplated or hereinafter discovered.

Signed……Date……..