



The purpose of a crystal healing session is for mental, spiritual and physical well-being. It is a form of energy healing which is an alternative or compliment to healing arts otherwise licensed by the State. Adison Martin, CCH is not a licensed physician, nor are energy healing services licensed or controlled in most states. A variety of techniques to facilitate well being and clarity in the moment will be used, while promoting long term self reliance through practical techniques to help raise consciousness, clear confusion, recognize intent, interpret meaning and quell doubt. A cure is not guaranteed and crystal healing is not a substitute for medical or psychological treatment, but only a supplement to these treatments. If at any time it is deemed necessary or advisable, our healing sessions will be discontinued to prevent any harm to you, to myself as healer, or to my healing practice.

NOTICE OF INFORMATION AND PRIVACY PRACTICES: In addition to personal and demographic information on the health history form, you are asked to disclose current and past medical history protected by the Health Insurance Portability and Accountability Act (HIPAA). As such, you have certain privacy rights in this information and, in compliance with the law, our HIPAA policy is attached to this form. All information we obtain about you, whether written or shared verbally during the session, and whether from you directly or another source, will be held in the utmost confidentiality. We will never share your information, medical or otherwise, without your express written consent and direction, unless otherwise required by law. While providing personal and medical information about you is entirely voluntary, without this information you may impair the progress of your sessions and potentially create risks to your health. If you have any questions about how to complete this form or the health history form, how we use your information, or what your rights are regarding your information, please ask your healer immediately before signing below.

PAYMENT is accepted in the form of cash, check or credit card (excluding American Express), due at the time services are rendered. Checks issued with insufficient funds will incur an additional \$15 fee, due and payable immediately.

CANCELLATION POLICY: Your appointment time is reserved especially for you. Kindly give 24-hours notice for cancellations so that other patients are able to receive necessary treatments during that time slot. Any cancellations made with less than 24-hours' notice will result in a charge of \$25.

CLIENT ACKNOWLEDGMENT & CONSENT TO RECEIVE SERVICES / RELEASE OF LIABILITY

I, _____ hereby request the service of Adison Martin CCH, for the purpose of assisting me to access my own inner resources of healing energy so that I may learn to heal myself. I authorize Adison Martin, CCH to administer any style of crystal/energy healing relevant to my diagnosis and treatment, including but not limited to the following (*please check any you **DO NOT GIVE** your consent for*):

- Placement of crystals on or around the body to balance chakras and restore energetic balance to the body. I agree to remain lying down during treatment and not to remove or manipulate the crystals.
- Cupping or tuina with or without the use of crystals may be used to promote circulation of Qi (energy). Cupping may produce a red/purple color, bruising or tenderness on the area treated lasting for 1-5 days.
- Meditation techniques and/or other techniques or exercises related to internal energy arts such as qi gong and tai chi, which may include but are not limited to introspection, light stretching and breathing exercises, may be taught to modify or prevent pain perception, normalize the body's physiological functions and facilitate emotional healing and physical growth.

I am aware that deep contemplation, physical contact and the risk of injury and emotional stress are inherent in the practice of energy work, meditation, movement, tuina, martial and other arts taught and/or performed by Adison Martin CCH, Conscious Crystal Healing and/or Adison Martin Martial Arts. I am also aware that certain



CONSCIOUS CRYSTAL HEALING

Client Disclosure and Consent Form

adverse side effects may result from the above treatments, which could include but are not limited to: bruising, sore muscles or aches, allergic reactions, and the possible aggravation of symptoms existing prior to treatment. I agree that I will inform the practitioner before beginning treatment if I have any known allergies, or if I am or could be pregnant or taking herbs or pharmaceuticals.

I understand that, while certain suggestions may be made that will assist me, and medical options may be explained to me in the course of my healing, these suggestions and explanations are in no way either a suggestion for medical treatment or any sort of diagnosis, prescription or medical directive, and do not constitute licensed medical advice. I waive any and all remedies I may have based on my own reliance on such information. I understand it is my responsibility to maintain a relationship for myself with a medical doctor. I hereby release Adison Martin CCH and Adison Martin Martial Arts from any and all liabilities or claims of any nature that may result from this crystal healing session, from the exacerbation of any preexisting physical ailments I may have, or from my failure to pursue medical attention or remedies for any physical ailments I may have, and I acknowledge that I have not been advised against pursuing such attention.

I have read, understand and consent to all the terms included in this Disclosure. I have been explained and understand the nature of the treatment, and have been informed of the risks and possible consequences involved with this treatment, if any. I have been given the opportunity to read my healer's HIPAA privacy policy, and have read (or waived my right to read) and understand its contents. I have been given an opportunity to ask questions pertaining to my treatment, and agree that it is my responsibility to seek any further information I feel I need. I also understand there is always a possibility of an unexpected complication and I understand that no guarantees or warranties can be made concerning the effectiveness or results of treatment, as results vary from person to person, and I take full responsibility for my expectations of the healing process. I have been informed that I have the right to refuse any form of treatment and that I am entitled to stop treatments at any time, with or without reason. I have consented to use the services offered, and agree to be personally responsible for all fees charged in connection with the services provided to me.

Client Signature *(Parent or Guardian signature is required if person listed above is under 18 years of age.)*

Client Printed Name

Date

Healer Signature

Date