DISCLOSURE & CONSENT

Please thoroughly read the following paragraph and then initial each paragraph after reading

_____ I understand that the CranioSacral therapist does not diagnose illness, disease or any other physical or mental disorder. In addition, the CranioSacral therapist does not prescribe medical treatment.

_____ I understand that CranioSacral therapy is considered to be a contraindication for recent and acute injuries to the head and neck, i.e.: recent whiplash, any recent fracture to the base of the neck or hemorrhage and state that I am not currently experiencing any of these conditions.

_____ I understand that Craniosacral therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

_____ Because a CranioSacral therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the CranioSacral therapist updated on my physical health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

I have completed the above information accurately and have read, understand and take responsibility for the above statements.

Signature_____Date_____

CANCELLATION POLICY

I understand that each appointment I have scheduled is very important, either for my own treatment process or that of another who could potentially fill the time slot. I agree to notify Thea Posch within 24 hours if I need to cancel an appointment. If I am unable to do this I understand that I will be responsible for payment for the scheduled time unless that appointment can be filled.

I have read and understand this cancellation policy

Signature_____Date_____