Consent to Craniosacral Therapy

I hereby consent for Julie Feinland to treat me with craniosacral therapy including such assessments and techniques which she may recommend. I understand that I may decline any assessments and techniques she recommends.

I acknowledge that Julie Feinland is not a physician and, when practicing craniosacral therapy does not diagnose illness, disease, or any other physical or mental disorder. I clearly understand that craniosacral therapy is not a substitute for a medical examination. It is recommended that I see my primary care provider for any ailments I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of treatment. I acknowledge that with any treatment there can be risks, those risks have been explained to me, and I assume those risks.

I acknowledge and understand that Julie Feinland must be fully aware of my existing medical conditions. I have completed my medical history form as provided and disclosed all of those medical conditions affecting me. It is my responsibility to keep Julie Feinland updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I have read the above noted consent and have had the opportunity to question the contents and my therapy. By signing the 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 Julie Feinland 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.

In addition, by signing below, I acknowledge and consent to the 24 hour cancellation policy and understand that I will be charged the full amount of the visit if I cancel less than 24 hours prior to the visit.

____

Date Patient Name (print) Patient/Guardian Signature