Energy In Motion Wellness

Client Information - Energy Balance Session

Name: ______________________ Preferred Phone: ______________________

Address: ______________________ Date of Birth: ______________________

City: ______________________ State: __________ Zip: __________

Email: ______________________ ☐ Female ☐ Male Pronoun: __________

Referred By: ______________________ Preferred form of Communication: ______________________

In case of emergency: ______________________ Phone: ______________________

Have you previously experienced energy work? ☐ Y ☐ N Muscle testing? ☐ Y ☐ N

If so, what type of energy work have you experienced? (please check all that apply)

☐ EFT Tapping ☐ Touch For Health ☐ Acupuncture ☐ Acupressure ☐ Reiki

☐ Jin Shin ☐ T.B.M. (Total Body Modification) ☐ A.R.T. (Autonomic Response Testing)

Other: ______________________

Please list relevant injuries, surgeries, illnesses and/or conditions (past, recent & chronic):

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Goal(s) for Energy Session:

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Client Signature ______________________ Date ______________________

Informed Consent

for Treatment with an Energy Therapy Approach

I have been informed about the new field of therapeutic practice that works with one or more aspects of the human energy system to bring about body-mind relief. In addition, I have been informed about scientific studies that are confirming the value of these approaches for releasing trauma and anxiety as well as increasing relaxation, reducing pain sensation, and enhancing a sense of well-being. I have been advised that there are currently no known side effects or detrimental results when energy-oriented treatments are properly administered by a qualified, experienced practitioner.

I further understand that, because these methods are relatively new, the extent and breadth of their effectiveness, including benefits and risks, are not yet fully known. I have been advised of the following:

- Vivid or traumatic memories may fade. This could adversely impact my ability to provide legal testimony regarding a traumatic incident.
- Reactions may surface during a session that neither my therapist nor I can fully anticipate, which may include strong emotional or physical sensations or bring memories of additional, unresolved memories.
- Emotional material may continue to surface after a treatment session and give indication of other incidents that need to be addressed.
- My practitioner may refer me to other practitioners who have specific skills to help with problem areas beyond his/her scope of practice.
- Light touch may be involved in assessment with clinical kinesiology (also known as muscle testing) for which I can choose to give permission or not. In addition, my practitioner may use selected touch to facilitate an intervention but will always ask for my full permission before using touch.
- I will be learning personal self-care with my own energy system as part of the therapeutic process.

I have considered the above information before agreeing to receive an energy therapy treatment and have obtained whatever additional information or professional advice I consider necessary to make an informed decision. I choose to participate in energy therapy of my own free will and know I have the right to cease using these methods at any time. I agree to take full responsibility for my self-care by sharing any discomforts or questions I have with my practitioner as quickly as possible

My signature acknowledges my choice to consent to the new and innovative approaches of energy therapy my practitioner offers. My consent is free from pressure or influence from any person or group.

Client Signature____ Date__________________

Practitioner Signature____ Date__________________

Office Policies

Practitioner Name: Leslie Cotham, CMT
Contact Information: 805-235-6297
leslie@energy-in-motion.net

Client Name: ______________________________ Date: ________________

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellations
While I understand that cancellations are sometimes necessary, I ask that you please give at least 24 hours notice prior to canceling. This allows the opportunity for someone else to schedule an appointment. Any missed or canceled appointments within 24 hours will be charged the full amount. Should an illness or emergency arise, an exception to this policy will be made at my discretion.

Late Policy
In order to provide consistency and reliability in scheduling for all my clients, I ask that you please be on time for your appointment. Should you arrive late, it may be necessary to reduce your massage to the time remaining, as I now need more time after appointments to sanitize. If I do not have a client immediately following, I may extend your time at my discretion to a full session. If I am able to do that, I will check with you to see if that fits into your schedule before proceeding.

Sickness
Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee will be waived.

Email List
Your signature below indicates that you give permission to be added to my email list. The email list is used to send out policy updates, annual specials and last minute appointment openings. You may opt-out at any time.

Financial Responsibility
Your signature below confirms your financial responsibility for all services.

Release of Medical Records
Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature ______________________________ Date ____________________