

HEALING TOUCH CLIENT AGREEMENT FOR SERVICES

Practitioner: Kathy A. Babula, Healing Touch Practitioner/Healing Touch Professional Association
344 North Ames Street, Matthews NC 28105
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I, _____, understand that Healing Touch is a holistic integrative therapy intended to clear, balance, and energize the human energy system in order to facilitate physical, emotional, mental, and spiritual self-healing. **I fully acknowledge and understand that it is accomplished through the use of contact and/or non-contact touch for which I give permission.**

NOTE: *Treatment goals will be mutually identified as part of the assessment and I have input in the goal-setting process for the benefit of my self-healing.*

Some of the indications for a Healing Touch session include, but are not limited to:

- Need to facilitate the relaxation response
- Need to reduce pain, anxiety, and stress
- Need to decrease nausea
- Support during chemotherapy
- Facilitation of wound healing
- Preparation for medical treatment/ procedures and to manage side-effects
- Support of emotional, mental, and spiritual healing



SESSION INFORMATION:

--Sessions are **60-75 minutes and cost \$75 per session**. Your practitioner is not a provider for any insurance carrier and will provide an invoice for sessions upon request.

--**Cancellation Policy:** I agree to give a 24-hour notice if I need to cancel an appointment. My practitioner reserves the right to charge me for the session if sufficient notice is not given.

--I understand that Healing Touch services are not intended to replace any currently prescribed medical treatments as ordered by my physician nor to replace any other medical care s/he has advised me to seek.

--I understand that my **Healing Touch Practitioner (HTP)** will neither diagnose nor prescribe for any condition that I might have.

--I understand that she is not licensed to practice medicine. I have been encouraged to consult a licensed medical practitioner when I deem it necessary.

--I agree to inform my practitioner of any changes in my health status.

CONFIDENTIALITY: I understand that all client information and records are treated in a confidential manner, under lock and key and/ or password protected. My experiences during these sessions are confidential and subject to the usual exceptions governed by state or federal laws and regulation, such as those requiring reporting threat of serious harm to self or others.

PRACTITIONER LIABILITY INSURANCE:

Tokio Marine Specialty Insurance Company for Members of the Healing Touch Professional Association

--Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Kathy A. Babula from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

My questions have been answered to my satisfaction regarding my **HTP's** background, Healing Touch, and what I might expect from this session.

I give my consent to receive Healing Touch sessions from **Kathy A. Babula, HTP**, and I understand that my willingness to learn about myself through these sessions is part of my healthy self-care.

Signature_____Date_____

Parent/ Legal Guardian Signature_____Date_____