General Office Policies for Simply Energy, LLC

www.simplyenergyllc.com, 508-277-6680

Name:	
Address:	
E-Mail:	
Home Phone:	
Cell Phone:	
Occupation:	
Referred by:	
Birth Month:	
Emergency Contact:	Relationship:
Phone # (s):	

Payment

- You will be expected to pay for each session at the time it is held unless we agree otherwise.
- I prefer cash or checks & can take a credit card
- Returned checks will incur a $35.00 fee, due and payable immediately

Cancellation Policy

- Out of respect for others that may be waiting for an appointment, I need to know of a cancellation at least 24 hours in advance of your scheduled appointment. Late cancellations will require payment in full for the missed session

Timing

- It is suggested that you arrive on time for your scheduled appointment. If you are late, we will still end on time and not run over into the next person's session.

Contacting me

- Simply Energy, LLC is open Monday through Friday. I am often with a client or otherwise not immediately available by telephone. When I am unavailable, you will reach my voice mail. I monitor my e-mail and voice mail frequently and will make every effort to return your call/e-mail on the same or next business day, with the exception of weekends and holidays. If you are experiencing a medical emergency, please call 911 or go to the emergency room of a nearby hospital

Simply Energy, LLC, reserves the right to dismiss clients for inappropriate conduct, non- or late payment of fees, safety concerns and other circumstances as determined by the energy practitioner.

I have reviewed, understood and agree to abide with the office policies as stated above.

Signature: _____ Date: _____

Print Name: _____

Consent to Treatment

I, _____ consent to be treated by Simply Energy, LLC, in one or more of the following forms.

- **Reiki**: Involves hands-on touch and visualization applied to the entire body, serving to align chakras and bring healing energy to organs and glands.

- **Eden Energy Medicine**: Education and instruction/demonstration and hands on energy balancing using Donna Eden's techniques, designed to balance energy throughout the body. May involve hands-on-touch.

    - Although Energy Medicine uses the term "medicine," it does not imply that Energy Medicine practitioners are practicing medicine. Energy Medicine is a term used by many training programs that teach people how to assess and correct for energy imbalances in the body. Energy Medicine is not a substitute for the diagnosis and/or treatment of medical or mental health conditions by a licensed health care professional. If you have a disorder that has been diagnosed by a licensed medical or mental health professional or a condition that should be evaluated by a licensed health professional, my services should be used only in conjunction with your obtaining that care. I do not diagnose or treat medical or mental health disorders, nor am I trained or licensed to do so. Energy Medicine attempts to optimize the body's overall health and vitality, but it is not to be used instead of appropriate care from a licensed professional.

  I understand the following is a possible side effect of this treatment:

    - While the methods I use and teach are gentle and considered non-invasive, it is possible that physical or emotional after-effects may occur after your energies have been stimulated and adjusted. In some instances, deeper pressure is used to move energies that may be blocked or congested in a particular area of the body, and this may cause some pain or discomfort. Dizziness, nausea, or anxiety is relatively unusual but not unheard of side effects to energy work. If any procedure is uncomfortable or leads to discomfort, please tell me at once. I will instantly stop if you request me to do so and can often provide a technique to counter the discomfort.

- **Essential Oils:** Essential oils are often used as part of a session. Please let the practitioner know if you have any allergies that will affect the use of certain oils _____ (please initial)

- **Richway Amethyst Crystal Biomat**

    - I have read and understand the contraindications for using the Biomat.
    - I understand the Biomat is used for the temporary relief of:
        - Minor muscle pain, minor joint pain and stiffness, joint pain associated with arthritis
        - Muscle spasms, minor sprains, minor strains
        - Minor muscular back pain
        - Relation of muscles, temporary increase of local circulation

  I understand the following is a possible side effect of this treatment: increased heart rate. If there is any questions about suitability to use the Biomat, specific medical advice should be obtained from a licensed health care practitioner.

I understand the nature of these treatments are not medical, have been informed of the risks and possible consequences involved with these treatments, and have been given an opportunity to ask questions pertaining to the treatments. I understand that no guarantee can be made concerning the results of the treatment. Simply Energy, LLC is <u>not a medical practice</u>, and is unable to provide a diagnosis or treatment for any illness or disease.

Signature: _____

Printed Name: _____Date: _____

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Notice of Privacy Practices

I keep brief records on each session, primarily noting the date of the session, the interventions used, and progress or obstacles observed as they relate to your goals in working with me. I will maintain your records for at least five years after our last contact, after which time I may securely dispose of them.

Client has the right: (1) to access their information; (2) to request that their information be amended; (3) to request that the use of their information be restricted; (4) to request alternative means of communications; and, (5) to complain about an entity's information protection procedures without fear of reprisal.

With the exception of special situations described below, you have the absolute right to the confidentiality of your sessions. I cannot and will not tell anyone else what you have told me, or even that you are working with me without your prior written permission. what you have told me, or even that you are seeing me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may under certain circumstances legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy to the best of my ability. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a session with you.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my Internet service provider.

Following are some exceptions to your right to confidentiality:

- There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state or local agency.
- If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and contact the police, a local crisis team, or a family member or other intimates.
- I may occasionally find it helpful to consult other professionals about a client. During a consultation, I make every effort to avoid revealing the identity of the client. The consultant is also bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

Your signature below indicates that you have read the information in this document, understand it fully, have discussed any questions or matters of concern with me and/or others, and agree to abide by its terms during our professional relationship

Signature: _____

Printed Name: _____ Date: _____

How are you feeling?

What would you like to get out of our work together? (primary reason(s) for seeking help)
How long did this problem(s) begin? Please be specific:
To what extent does this interfere with your daily activities?
Have you been given a diagnosis? If so, what?
What other kinds of treatment(s) have you tried? How well did they work?
Previous experience with other complimentary therapies:
Other health care professionals, and holistic practitioners you are currently working with: 1. 2. 3. 4. 5.

Currently:	**YES**	**NO**
Pregnant		
External Pacemaker		
Pacemaker with defibrillator		
Renal or Kidney failure		
Heat sensitive MS		
Going through radiation therapy		
Going through chemotherapy		
Brain tumor		
Metal body parts including plates or screws		
Wearing any kind of pain patch		

Your History	Dates	Your History	Dates
Hyper/Hypo Thyroid		High/Low Blood Pressure	
Heart Disease		Diabetes/Hyper/Hypoglycemia	
Circulation issues		Depression	
Anxiety		Skin Disorders (eczema, psoriasis…)	
Allergies (list on p. 6)		Asthma/lungs	
Seizures		Stomachaches	
Constipation/Diarrhea		Sinus Issues	
Headaches		Hepatitis/Liver	
Eating Disorders		Stroke:	
Cancer		Other mental health:	
Other:		Other:	
Other:		Other:	

Current Medications	Purpose	Since when?	Adverse Reactions?

Current Supplements	Purpose	Since when?	Adverse Reactions?

Significant traumatic events in your life, including auto accidents and falls and approximate dates:

Surgeries and approximate dates:
Allergies: food, medication, environmental, etc… What is your reaction?
How do you manage stress? What are your current self-care tools?
Do you exercise regularly? If so, describe your exercise program:
Current or history of Alcohol/drug problems?
Do you smoke Tobacco? Frequency? Do you smoke Marijuana? Frequency?
What is your current energy level?
How is your sleep? How many hours per night do you sleep?
Do you crave sugars or carbohydrates?
Do you drink caffeinated beverages? How many per day?
What is your daily water intake? ( ) 8 oz glasses per day

I waive any liability towards Julie Fowler or Simply Energy, LLC that may arise due to any omission or misrepresentation of my health.

Signature: _____

Printed Name: _____ Date: _____