THIS FORM IS CONFIDENTIAL AND NOT AUTHORIZED FOR RE-RELEASE

Hypnotherapy Intake Form

Tiffany R. Warner, LCSW

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Name:_____ **Date of Birth:**_____

Address:_____

Primary Reason for Seeking Hypnotherapy:_____

Please read the following carefully, and when you are sure that you understand the statement AND agree to the terms, please sign and date in the spaces provided:

I , _____, understand that hypnotherapy is not a substitute for appropriate medical treatment for any disorder or disease. I also understand that if at any time I feel uncomfortable during my session I will make this clear and the session will be stopped immediately. I am aware and understand that not following the protocol regarding attending all sessions in my treatment plan in a timely fashion may negatively affect the outcome of my treatment. I understand that failing to give 24 hours notice of cancelation of an appointment will result in being charged for that appointment.

In addition, I understand any and all information regarding myself or my treatment in this office will be kept strictly confidential in accordance with current HIPAA regulations.

Signed:_____ **Date:**_____