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Hypnotherapy Intake and Consent to Treatment

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. Your signature also indicates that you agree to treatment.

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 manner may negatively affect the outcome of my treatment. I understand that failing to give 24 hours notice of cancellation of an appointment will result in being charged for that appointment.
I further acknowledge and agree that if I am seeking hypnotherapy to address unwanted habits, cravings, or addictions that adverse images or unpleasant tastes may be used during my treatment in order to achieve the desired results.
In addition, I understand that all information regarding myself or my treatment in this office will be kept strictly confidential in accordance with current HIPPA regulations.

Client Name (Please Print):____

Client Signature:____

Parent or Legal Guardian:____

Date:___________________