OSIANA WELLNESS

Osiana Wellness
Craniosacral Therapy – Theta Healing
Informed Consent and Liability Release Waiver

Please read and initial:
____ I understand that the Craniosacral Therapy / ThetaHealing practicioner does not diagnose illness, disease, or any other physical or mental disorder. In addition, the practitioner does not prescribe medical treatment or pharmaceuticals.
____ I understand that Craniosacral Therapy / ThetaHealing is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.
____ I understand that Craniosacral Therapy is considered to be a contraindication for recent fractures to the base of the skull and neck, and state that I am did not recently experience a fracture in these locations.
____ Because a Craniosacral Therapy practitioner must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the practitioner updated on my physical health. Further, I release the practitioner from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.
____ I understand that each appointment I have scheduled is important, either for my own treatment process or that of another who could potentially fill the time slot. I agree to give 48-hour notice if I choose to reschedule or cancel an appointment for any reason other than a family emergency or sudden illness. If I cancel without 48-hour notice or do not show up to my appointment, I agree to pay the full cost of the sessions unless Osiana Wellness is able to fill the appointment time.

Name of client: _____ Date: _____

Signature of client (or guardian if under 18):_____

I have completed the information in my Client Information Form accurately and have read, understand, and take responsibility for the above statements.