

ENERGY FOR LIFE CONNECTION
Stacey Quade, CHTP/I, COTA, Herbalist
Certified Healing Touch
Practitioner/Instructor
Certified Occupational Therapist
218-591-2104

GREAT LAKE THERAPIES
Joseph Quade, MPT, CHTP
Master of Arts Physical Therapist
Certified Healing Touch Practitioner
218-341-1205

507 N Blackman Ave Duluth MN 55811

NAME _____
ADDRESS _____
PHONE _____

I understand that Healing Touch therapy/Herbal remedies/Manual Therapy, given here are for the purpose of stress management, reduction of muscular tension to remove congestion, and/or for increasing circulation and energy flow.

All herbal remedies are provided based on client information/interview and have been considered for benefit/contraindication.

I understand that the Healing touch practitioner/herbalist, or manual therapist, does not diagnose illness, disease, or any other medical treatment of any kind.

I understand that Healing Touch Therapy/herbal remedies or manual therapy is not a substitute for medical examination, diagnosis, or treatment, and that it is recommended that I see a physician, naturopath, chiropractor, or another health care practitioner for any ailment I might have.

I agree to inform the practitioner of all my known medical conditions on this date and take it upon myself to keep the practitioner updated on my physical health.

I consent to the practitioner consulting with other practitioners who are involved in my healthcare regarding pertinent information related to my healing.

I further agree to immediately inform the practitioner of any pain or discomfort during the session.

I agree to hold the Healing Touch practitioner/herbalist or manual therapist harmless for any problems that might arise as a result of my treatment/therapy sessions.

To avoid being charged for missed appointments, I must cancel at least 24 hours in advance. A \$20.00 fee will be assessed on all returned checks.

I have read this release in its entirety, and fully understand its terms. I knowingly and voluntarily agree to those terms. I have received a copy of the Client Bill of Rights.

Signature _____ Date ____/____/____

Parent/Guardian _____