Hibiscus MOON
— Crystal Academy —

INTAKE CONSENT FORM

This Intake and Consent Form has been given to you to provide valuable information in assisting your therapy. While sharing most information in this Form is voluntary, you must fill out the contact information immediately below, as well as sign and initial the consent at the end of this Form, for us to work with you. In addition to personal information, you are asked to disclose current and past medical history protected by the Health Insurance Portability and Accountability Act. As such, you have certain privacy rights in this information and, in compliance with the law, our HIPAA policy is attached to this form. All information we obtain about you, whether written or shared verbally during session, and whether from you directly or another source, will be held in the utmost confidentiality. We will never share your information, medical or otherwise, without your express written consent and direction, unless otherwise required by law. While providing personal and medical information about you is entirely voluntary, without this information you may impair the progress of your sessions and potentially create risks to your health.

If you have any questions about how to complete this form, how we use your information, or what your rights are regarding your information, please ask your practitioner immediately before signing below.

Today's Date: _____

Client Full Name: _____

Date of Birth: _____

Email: _____

Preferred phone: _____

Alternate phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Person (Name & Phone Number):

_____

MEDICAL CONDITIONS (CIRCLE ALL THAT APPLY):

☐ *Thyroid Disease*	☐ *Heart Problems*	☐ *Joint/Muscle Pain*
☐ *Hypoglycemia*	☐ *Inner Ear Problems*	☐ *Asthma*
☐ *Anemia*	☐ *Depression*	☐ *Diabetes*
☐ *Allergies*	☐ *Addictions*	☐ *Eating Disorders*
☐ *Anxiety Disorders*	☐ *Cancer*	☐ *Claustrophobia*
☐ *Food Sensitivities*	☐ *Headaches*	

Other condition(s):

PERSONAL BACKGROUND

Are you pregnant? **Circle:** Yes/No

What is your previous experience with crystal therapy? Please share.

Have you ever undergone counseling? Please share.

Do you meditate? Please share.

What is your most volatile or vulnerable emotion?

What issue(s) do you want addressed during crystal therapy?

I feel the following emotions frequently:

I cannot feel the following emotions often/well:

How would you describe your spiritual beliefs, if any?

What are your current expectations of crystal therapy?

Please check all that apply:

☐ I have experienced crystal therapy before

☐ I have experienced a Reiki session before

☐ I have had an energy balancing session before

☐ I know about chakras

☐ I have used holistic remedies before

☐ I have a spiritual path that I am consciously following

☐ I have experienced trauma

☐ I have difficulty adjusting to new situations and or people

☐ I am generally uncomfortable with touch

☐ I am generally uncomfortable expressing myself

☐ I love myself

☐ I accept myself

☐ I am comfortable expressing myself

☐ I feel like I belong

Consent and Release of Liability

Please initial next to each line below:

____ I am requesting the service of _____, a practitioner, for the purpose of assisting me to access my own inner resources of therapy energy so that I may learn to heal myself.

____ All information I have provided in this Intake and Consent Form is accurate to the best of my knowledge

____ I understand no guarantees or warranties are made to the effectiveness of crystal therapy, and take full responsibility for my expectations of the therapy process.

____ I understand the associated risks of crystal therapy, if any, as explained by the crystal practitioner, and agree that it is my responsibility to seek any further information I feel I need.

I ____ did ____ did not provide medical information in this form, and ____will ____ will not be giving permission to share this information with third parties.

____ I have been given the opportunity to read my practitioner's HIPAA privacy policy, and have read (or waived my right to read) and understand its contents.

____ I understand that, while certain medical options may be explained to me in the course of my therapy, these explanations are in no way either a suggestion for medical treatment or any sort of prescription or medical directive, and do not constitute licensed medical advice. I waive any and all remedies I may have based on my own reliance on such information.

____ My practitioner signed a Client Disclosure Form in my presence such that I understand its contents and I accept its terms, without condition.

____ I agree to pay my practitioner directly by _____ (method), at the time of service, or on _____.

____ I agree to pay, whether or not my practitioner has forgiven or waived a charge in the past, all the following non-refundable fees, without exception:

$ _____ Appointments lasting _____ minutes.

$ _____ Appointments lasting _____ minutes.

$ _____ Appointments lasting _____ minutes.

$ _____ All other appointments.

$ _____ Late Cancellation (less than 24 hours before appointment time).

$ _____ Bounced checks.

$ _____ Per late payment, if/when accepted.

____ I release my practitioner, as well as any of his/her assistants or related business interests, from any and all liabilities or claims of any nature that may result my participation in crystal therapy, including but not limited to damages from my failure to pursue medical attention from a medical professional, for the exacerbation of any preexisting physical ailments I may have, and

By signing here, I agree to all these terms, and further bind my estate, heirs, and assigned to this release of liability.

_____ _____

Client Signature Date