

CONSENT FORM

I, _____(print name) consent to treatment for myself (or my minor child) _____
(print name), and understand that the services provided by the practitioner Jeanette Stillingner is intended to enhance
relaxation and increase communication within my body.

I understand that these services are not a substitute for medical treatment or medications. I am aware that diagnosis is not
given and medication is not prescribed. I agree to continue to have regular medical check-ups as part of my overall health
care plan.

I understand that participation is voluntary and that at all times I may choose to end my participation. I understand that I
may experience 'healing reactions' during the 24 to 48 hours following the services provided.

I understand that any information exchanged during any session is educational in nature and is to be used at my own
discretion. I also understand that any information imparted during these sessions is strictly confidential in nature and will not
be shared with anyone without my written permission. I do, however, give the practitioner consent to use my case history and
results without using my name. I understand that only the practitioner Jeanette Stillingner will have access to information in
my file to enhance my healing.

I understand that by providing this informed consent I am assuming full responsibility for my services and I hold harmless both
the practitioner Jeanette Stillingner and the facility/location where the services are provided.

I agree to the terms and conditions set out by this consent form and certify that the above information is true and correct. I
agree to pay for distance sessions, should I request them.

SIGNATURE _____

WITNESS SIGNATURE _____

DATE _____

WITNESS PRINT NAME _____