GENTLE REFLECTIONS ENERGY HEALING

Client Consent & Scope of Services

Client Name: _____
Date: _____

Scope of Services

Gentle Reflections Energy Healing provides complementary wellness and personal-growth services intended to support relaxation, self-exploration, emotional awareness, stress reduction, and personal well-being. Depending on my goals and the service selected, sessions may incorporate practices such as energy healing, sound healing, meditation, guided visualization, hypnotherapy, PSYCH-K®, EFT, reflective exercises, expressive or creative practices, and other complementary approaches within the practitioner's training and scope of practice.

These services are **not a substitute for medical care, psychological or psychiatric treatment, diagnosis, or emergency services**. No diagnosis, treatment, cure, or prevention of a medical or mental-health condition is promised or implied. I understand that I should consult an appropriately licensed healthcare or mental-health professional regarding medical, psychological, psychiatric, or other clinical concerns and should not discontinue prescribed treatment or medication based on anything discussed during a session.

Client Consent

I understand that participation is voluntary and that I may ask questions, decline an exercise or technique, pause a session, or end a session at any time.

I understand that personal memories, thoughts, emotions, sensations, or other experiences may arise during some forms of self-exploration or hypnotherapy. I understand that responses vary from person to person and that no particular outcome is guaranteed.

I agree to provide accurate information that may be relevant to my participation and to communicate any concerns, discomfort, or changes in my circumstances that may affect my ability to participate safely.

I understand that Gentle Reflections Energy Healing does not provide emergency or crisis services. If I am experiencing an emergency or believe I may be a danger to myself or someone else, I will seek appropriate emergency or crisis assistance.

Acknowledgment

By signing below, I acknowledge that I have read and understand the scope and nature of the services described above. I voluntarily consent to participate in the services I have selected and understand their complementary, non-medical nature.

Client Signature: _____

Printed Name: _____

Date: ___

Practitioner: _____

Date: ___