Participation Agreement

Kimberly Penning provides the following services:
Sound Therapy (Biofield Tuning, VST), Recover Coaching and Hypnotherapy

This following information will be used to aid in serving you. Please answer honestly and know that answering yes or no to any particular question does not mean that you cannot receive services from this practitioner. Your honest answers serve in your receipt of appropriate care and service. All information will be kept confidential within the Health Insurance Portability and Accountability Act (HIPAA) regulations.

Name_____

Address_____Apt_____

City_____State_____Zip Code_____

Email Address_____

_____ Initial that you agree to the use of email correspondence

_____ Initial that you agree to receive a customized self-hypnosis MP3 via email

Phone number you prefer to be reached at (____)_____

_____ Initial if you agree to receive text messages

Is it ok to leave phone messages or text you at this number? _____

Age _____ Marital Status _____

1. What is the main issue you wish to work on?

2. Medical Conditions or challenges:

3. Are you currently under a physician's care for any of the above conditions?
   a) If so, name of physician:

Participation Agreement, continued

4. When was your last visit with a physician?
    a) Was anything about this visit notable? If so, explain briefly:

5. Are you currently taking any medications I should be aware of such as psychotropic medications?
    a) If so, what are the names of the medications, and how do they affect you?

6. Have you spoken to your physician about biofield tuning, vibrational sound therapy, brainspotting or hypnotherapy as an adjunct to your treatment?

7. Have you ever used this type of service?
    a) If so, briefly explain your experience:

8. Have you ever had any mental health treatment, such as with a counselor, therapist, psychologist or psychotherapist?
    a) If so, give a brief history of your mental health treatment and the results of your treatment:

9. Are you receiving any mental health treatment now?
    a) If so, name of mental health professional:
    b) Have you spoken to your mental health professional about hypnotherapy as an adjunct to your treatment?

10. Do you have thoughts of hurting yourself or taking your own life?

11. Were you referred to me?
    a) If so, by whom?
    b) May I thank this person for your referral?

12. Briefly describe your spiritual/religious beliefs or life philosophy:

Participation Agreement, continued

Other issues or areas I would like to work on:

__ Stress
__ Guilty or Angry Feelings
__ Fears, Phobias or Trauma Recovery
__ Low Self Esteem or Shyness
__ Lack of Motivation
__ Body Shape
__ Spiritual Growth
__ Forgiveness
__ Relationship Issues
__ Job Performance
__ Unwanted Habits
__ Smoking Cessation
__ Sports Performance
__ Self Confidence
__ Test Taking/ Accelerated Learning/ Memory Improvement
__ Chronic Pain (already assessed by a physician)
__ Accelerated Healing (already assessed by a physician)

Other:

_____

_____

Agreement:

Like the practice of medicine, Biofield Tuning, Vibrational Sound Therapy, Brainspotting, Hypnotherapy and Regression are not absolute sciences. I personally know of no case or record where an individual has been harmed by the use of these methods. I do know of many of cases were people of all walks of life have benefited greatly from the use of these methods. As a general practice, it is necessary for everyone taking part in private sessions, classes, workshops and seminars with Kimberly, to sign this Release of Liability Agreement.

I am of legal age, and in consideration of my acceptance as a participant in this private Hypnotherapy or Biofield Tuning, Vibrational Sound Therapy, Brainspotting, Seminar, Workshop, I for myself, my heirs, my executors, administrators and assignees, do hereby release and discharge Kimberly Penning or other participants in any of the activities, from all claims of damages arising from my participation in said activities. I agree that any claim of damages or disputes arising from my participation in above mentioned sessions, should it arise, shall be settled by binding arbitration before an extra-judicial arbitration and mediation service. I further understand that recordings may be made at any of these events, and that Kimberly Penning and her organization retain the copyright to all of these recordings.

Signature _____ Date _____

Participation Agreement, continued

Confidentiality of Information

Co-therapists have a right to expect that information revealed in sessions not be disclosed without extraordinary justification. The conditions that justify the release of information and by law must be reported to the appropriate agencies, are the following:

1. Knowledge of child abuse or neglect.
2. Knowledge of senior citizen abuse or neglect.
3. A co-therapist poses a serious risk of suicide and is an imminent danger to self.
4. A co-therapist poses a threat of imminent danger to another.
5. A Judge, by issuance of a court order, may obtain information.
6. Report to law enforcement authorities knowledge of a felony that has been, or is being committed.

In other situations, signed authorization for release of information is required.

Signature _____ Date _____

Kimberly Penning tCADC, CHT_____Date _____

Participation Agreement, continued

In order to be more successful in reaching my goals, **I agree to**:

1. Be an active participant in my experience and see myself as a partner in the transformative nature of this process.
2. Recognize that my thoughts, feelings, images and actions have a direct effect on the quality of my life.
3. Acknowledge that my well-being depends directly on how well I care for myself physically, emotionally, intellectually and spiritually.
4. Take responsibility for my experience of life, because I create my life to the best of my ability in the moment, with what I know right now.
5. **I agree to be on time for my sessions, allow at least 24 hours of advance notice should I need to cancel or reschedule a session and understand that session will be considered complete if I fail to do so. (229) 630-5333. A fee of $50 will be collected if I no-show to my appointment without notice.**

I understand that all services provided by Kimberly Penning are for educational and self-improvement purposes only. I further understand that these services are not the practice of medicine or psychotherapy and are, therefore, not offered as a replacement for counseling, psychotherapy, psychiatric or medical treatment.

Fees may vary due to a variety of packages and discount options available, the below mentioned fees are for a single session though some services require a minimum of 3 sessions (Hypnotherapy and Brainspotting), Hypnotherapy is only available in a 120 minute session.

Fees: Fees vary depending on package purchased, amounts listed are for individual sessions.
$100 – 60 Minute Session
$150 – 90 Minute Session
$150 – 120 Minute Session (Hypnotherapy)

Signature _____ Date _____

Kimberly Penning tCADC, CHT_____ Date _____