



11479 S Pine Drive, Suite #28
Parker, CO 80134
Phone: 303.550.4110
www.EganHypnotherapy.com

Thank you for choosing Egan Hypnotherapy.

Please read and sign this form before completing the rest of the forms.

During your visit to Egan Hypnotherapy, you will meet with Angela (Angie) Egan, a Board Certified Hypnotist from the National Guild of Hypnotists to learn about hypnosis and how it can help you achieve your goals. All scheduled visits will include a customized hypnotic session. **Sessions are scheduled as 60 minutes.** We try to keep to a strict schedule, but occasionally run long. If we're running a little off-schedule, please know that it's always for a good reason.

Hypnosis is a very powerful process that has helped millions of people make changes that they want to make in their lives. However, hypnosis is not "mind control." For example, no one, not even the very best hypnotist, could MAKE you change your habits or behaviors. Ultimately, you are responsible for the changes that occur as a result of the hypnosis sessions. There is always a human factor. Doctors don't guarantee that you will get well. Teachers can't guarantee that you will learn, and lawyers can't guarantee that you will "win" your case. **At Egan Hypnotherapy, what we can guarantee is the very best service using current information and appropriate hypnotic techniques for your situation.**

Our goal is to provide you with the most effective hypnosis process in the most efficient use of your time. We begin your process with a systematic series of sessions that include customization for your unique set of needs, continued reinforcement, and self-hypnosis training. Many clients reach their goals in the initially scheduled sessions, and most people (but not everyone) begin to experience benefits from the very first session. Hypnosis is a process. Many clients elect to schedule follow-up sessions for reinforcement or coaching.

"By signing this, I understand that hypnosis and hypnotherapy are not meant to diagnose or treat any disease, but rather it is intended to provide information, education, and motivation that will promote feeling better, healing faster, and generally being more effective. It is designed to give me insight and tools into my innate healing potential and guide me into being more effective in helping myself. I also realize that hypnosis and hypnotherapy are not a substitute for conventional medicine, and I have been encouraged to seek the advice of a licensed health care provider should I choose to with regard to treating me for specific medical or psychological problems. I accept responsibility to share the enclosed "Dear Health Care Provider" letter with my doctor to notify my use of hypnotism

By signing this, I am stating that I have read this form and understand that, like the other healing arts, the practice of hypnosis and hypnotherapy, is not an exact science: Therefore, results are not guaranteed, nor are refunds given for services rendered."

Signature _____

Date _____



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Confidential Client History Form

Client Name _____ Parent/Guardian Name (if applicable) _____
Date _____ Mobile Phone _____
Address _____ City _____
State _____ Zip Code _____ Email _____
Date of birth _____ Age _____ Occupation _____
How did you hear about us? _____ If a referral, who may we thank? _____

Medical History

Please list any accidents, illnesses, medical problems or major issues:

Was there abuse in your childhood/history? Yes _____ No _____

If so, was it: Physical _____ Emotional _____ Verbal _____ Sexual _____

Have you ever been treated for? Heart Problems _____ Diabetes _____ Epilepsy _____ Pain _____
High Blood Pressure _____ Anxiety Attacks _____ Eating Disorders _____ Seizures _____
Insomnia _____ Depression _____ Mental Health Disorders _____

Indicate your use and frequency of the following:

Tobacco Yes _____ times per _____ Alcohol Yes _____ times per _____
Recreational Drugs Yes _____ times per _____ Caffeine Yes _____ times per _____

Please list any prescription medications you are currently taking: _____

I understand that sessions at Egan Hypnotherapy may be audio-recorded and become part of my confidential record. By signing this form, I confirm that all information is true to the best of my knowledge. If I am signing this document on behalf of a minor, I understand that all information shared by the minor to the hypnotist during the session is confidential, and can only be shared with the minor's consent, unless there is a reason to believe the minor will harm themselves or others. By signing this form, I accept responsibility to share the enclosed "Dear Health Care Provider" letter with my doctor to notify my use of hypnotism."

Client Name (Please Print)

Client Signature



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I would like to work on:

Making this change will allow me to:

- ❖ _____
- ❖ _____
- ❖ _____

After addressing my issue, in one week I see myself: _____

After addressing my issue, in one month I see myself: _____

After addressing my issue, in one year I see myself _____

In my down time, I love to:

My favorite thing about me is:

The thing(s) that can always bring a smile to my face is:

One of my favorite childhood memories is:

Mandatory Disclosure

1. Contact Information: My name is Angela (Angie) Egan, CHt. I can be contacted through my office: 11479 S Pine Drive, Suite 28 Parker, CO 80134 or by telephone at 303.550.4110 or via email at angie@eganhypnotherapy.com

2. Education and Training: I was trained in hypnotism through the Professional Hypnotherapy Certification Program through the National Guild of Hypnotists. I am a Certified Member of the National Guild of Hypnotists and I complete annual continuing education to maintain my training at a high level. The National Guild of Hypnotists is the oldest and largest hypnotism organization in the world and its certification is the most widely recognized credential for the professional practice of the hypnotic arts.

3. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Board of Psychotherapist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals:

- Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
- Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.
- Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.
- Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.
- Licensed Social Worker must hold a master's degree in social work.
- Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.
- Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision.
- A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

4. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in § 12-43-218 C.R.S., as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (§ 12-43-101, C.R.S., et seq.) is available at: www.dora.colorado.gov/professions/registeredpsychotherapists.



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5. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

6. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

7. I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

Print Client Name: _____

Client Signature or Responsible Party's Signature _____

Date: _____

If signed by Responsible Party, please state relationship to client and authority to consent:



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Dear Health Care Provider:

I have been contacted by your patient requesting instruction in self-hypnosis. It is my policy to be sure that the attending physician or other health care provider is aware that the patient is practicing hypnotism and will likely experience less worry and discomfort than other patients. Research suggests there may be other general health benefits as well.

Consulting Hypnotism is motivational coaching by means of hypnotism and is not considered health care. Therefore, health insurance does not normally cover hypnotism and your patient will be paying me directly for my services.

If you have any objection to your patient receiving hypnotism would you inform me? If there is anything in particular you would like to include in my work with your patient, please let me know.

I am a Board Certified Hypnotist in good standing with the National Guild of Hypnotists and my continuing education is current. I practice in accordance with the Code of Ethics, Standards of Practice and Recommended Terminology of the National Guild of Hypnotists, and give every client a comprehensive Client Bill of Rights which fully discloses my training and practice limits.

Please feel free to learn more about my services and background from my web site. I would also be happy to discuss my services with you at your convenience.

Sincerely,

Angie Egan

Angie Egan
Board Certified Hypnotist



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I, _____ authorize Egan Hypnotherapy and Angie Egan
(Your Name)

to discuss my hypnosis/hypnotherapy sessions with: _____
(Name of Professional)

My hypnotist has my permission to discuss the following items with the above- mentioned Professional:

_____ All aspects of the hypnotherapy sessions;

_____ Some of aspects of the session, specified as follows:

I understand that in order to revoke this release I must provide that request in writing.

Signed:

Signed:

Client

Parent/Guardian
(If client is a minor)

Printed Name

Printed Name

Date

Date



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PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

The standard meeting time for hypnotherapy is 60 minutes. The structure of the session is as follows; 15-25 minutes discussing the focus of that hypnotherapy session, 25-30 minutes in hypnosis with remaining time going over follow up practices and questions. It's your responsibility to be on time for your session and understand the session structure. If you arrive late, that time is deducted from your session. Additionally, if more than 25 minutes is spent discussing the focus of your hypnotherapy, the time spent in hypnosis will be shortened to stay within the 60-minute window.

Cancellations and re-scheduled session will be subject to a full charge if not received 24-hours in advance. We understand that one-time circumstances, such as illness, occur. If this happens, please contact Angie directly at 303-550-4110 to see if the cancellation fee can be waived. The cancellation policy is necessary because a time commitment is made to you and is held exclusively for you. As stated above, if you are late for a session, you will lose some of that session time.

TELEPHONE ACCESSIBILITY If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.



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All existing confidentiality protections are equally applicable.

Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to treatment, better continuity of care, and reduction of lost work time and travel costs. Effective treatment is often facilitated when the healthcare provider gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. The provider may make assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in services, potential risks include, but are not limited to the provider's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the provider not being aware of what they would consider important information, that you may not recognize as significant to present verbally to the provider.

MINORS

If you are a minor, your parents may be legally entitled to some information about your treatment. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the treatment is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If treatment is terminated for any reason or you request another provider, I will provide you with a list of qualified hypnotists to treat you. You may also choose someone on your own or from another referral source.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Print Client Name: _____

Client Signature or Responsible Party's Signature _____

Date: _____