This Intake and Consent Form has been given to you to provide valuable information in assisting your healing. 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 available for your review. 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.

CLIENTS CONTACT INFORMATION:

Date	Clients Name
Birthdate	Email
Cell Phone	Address
Home Phone	City, State, Zip
Emergency Contact #	Emergency Contact Name

PERSONAL BACKGROUND

MEDICAL CONDITIONS (CIRCLE ALL THAT APPLY):

Addiction	Allergies	Anemia	Anxiety Disorder
Arthritis	Asthma	Cancer	Claustrophobia
COPD	Dementia	Depression	Diabetes
Eating Disorders	Epilepsy	Food Sensitivities	Headaches
Heart Problems	High Blood Pressure	High Cholesterol	Hypoglycemia
Inner Ear Problems	Joint/Muscle Pain	Kidney Disease	Multiple Sclerosis
Osteoporosis	Parkinson’s Disease	Stroke	Thyroid Disease
Other			

Are you pregnant? Circle:

Yes	No

Circle any/all of the following natural/energy health sessions you've experienced:

Acupuncture	Acupressure	Aromatherapy	Crystal Healing
Energy Healing	Massage	Meditation	Reflexology
Reiki Healing	Sound Healing	Spiritual Life Coach	Yoga Practice

Please share your previous experience with any of the above sessions.

_____

_____

List any chronic physical pain you may have.

_____

_____

Have you ever undergone counseling? Please share.

_____

_____

Circle any of the below words that best describe emotions, feelings or behaviors you may have frequently:

Aggressive	Angry	Annoyed	Anxious	Ashamed	Bitter
Critical	Caring	Confused	Competitive	Depressed	Determined
Discouraged	Disgusted	Eager	Embarrassed	Energetic	Envious
Excited	Fearful	Foolish	Frustrated	Guilt	Happy
Hording	Hurt	Inadequate	Insecure	Inspired	Irritable
Jealous	Joy	Judgmental	Lonely	Loving	Miserable
Motivated	Nervous	Overwhelmed	Peaceful	Proud	Restless
Resentful	Sad	Shame	Self-conscious	Shyness	Silly
Stupid	Suspicious	Tense	Trapped	Worried	Worthless
Workaholic	Other				

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

_____

_____

What are your current expectations of crystal healing?

_____

_____

Consent and Release of Liability

Please initial next to each line below:

____ I am requesting the service of Kathy Rountree, for the purpose of assisting me to access my own inner resources of healing 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 healing, and take full responsibility for my expectations of the healing process.

____ I have been explained and understand the associated risks with my practice of crystal healing, if any, 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 healer'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 healing, 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.

____ I have been given the opportunity to read The Client Disclosure Form (or waive my right to read) and understand its contents and accept its terms, without condition.

____ I agree to pay KR Crystal Essentials directly by cash or check, Venmo or Apple Pay at the time of service. Please refer to www.krcrystalessentials.com for services and pricing.

Policies

Late Policy

My time is valuable as is yours. If you are late for an appointment, your session cannot be extended beyond the scheduled time meaning you will simply lose that time.

Cancellation Policy

If you need to cancel or reschedule your appointment, please let me know 24 hours prior to your appointment or as soon as possible. If you don't show up for an appointment, you'll be charged half the cost of the services scheduled on or before your next appointment and all future appointments must be paid for in advance.

$ Half of the cost of service(s) scheduled - No Show / Late Cancellation (less than 24 hours before appointment time).

$ 25.00 Bounced checks. (or bank fee if more than $25.00)

____ I release my healer, 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 healing, 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