BOWENWORKS MAGIC: OFFICE POLICY

Philosophy: Provide a safe, gentle, effective, holistic, manual therapy for the assistive treatment of medical problems, to enhance health and to promote a natural healthy aging process.

There are no reported side effects or negative outcomes of Bowen Therapy. Sometimes a patient can go through "healing pain" which can, on occasion, be intense and last several days.

IF you are PREGNANT or might be PREGNANT, or if you have BREAST or PEC IMPLANTS, PLEASE tell us. There are some Bowen moves that should be cautiously, or not be- performed.

Sessions are from 20 to 60 minutes long. Follow-up visits for Bowen are best scheduled one week apart. The total number of visits depends on the situation being addressed. Patients remain fully clothed during the visit. We request that shorts be worn or pants may be opened so that we may have at least one hand on your skin, to assist in the quality Bowen moves. IF YOU find this problematic, PLEASE let us know.

Financial: Payment is expected at the time of the visit. WE DO NOT ACCEPT INSURANCE at this time. If you need bills to send to your insurance for reimbursement of services, please let us know.

We do not give medical advice or dispense medications. We may offer ideas regarding Bowen home exercises, soaks etc. You may be encouraged to see your Primary Care Physician for some matters.

Please give 24 hours' notice for appointment cancellations**. Less than 24-hour cancellation OR no-show** may result in a **Full Charge for that appointment slot.** Respect that others need Bowen too**.**

Scents: We ask that clients bathe within 12 hours of and refrain from wearing perfume or essential oils on the day of their visit. Others may be sensitive to these smells and can have reactions.

*** CONSENT FOR PHOTOGRAPHY/VIDEO EVIDENTIALS**

*I consent (YES) (NO) to having a facial picture for my/my child's office file.
*I consent (YES) (NO) to having a pre and post picture or video taken to document significant changes. in my/my child's body mechanics or positioning.

Name/Signature _____/_____ Date_____

*** CONSENT FOR TREATMENT**

I have read and understand the above and agree to be treated or have my child treated.

Name/Signature _____/_____ Date_____

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If a Minor is being treated, You are the parent or designated /authorized caregiver? (YES) (NO)

Name/Signature _____/_____ Date_____