CLIENT DISCLAIMER FORM

TO BE ATTACHED TO CONSULTATION FORM.

**Please read carefully and only sign if you are in full agreement with its contents.**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ confirm that I have fully understood the treatment I am to receive and I confirm that I am willing to proceed without confirmation from my GP or consultant. I confirm I have no illness or diseases or underlying problems that would prohibit me from receiving a treatment. I accept full responsibility for my health and decisions. I discharge Patricia Jordon/Rainbowwisdom from any claim, cause of action or liability for damages arising from any personal injury including emotional distress.

Or

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ confirm that I have understood the treatment and given my medical history I prefer to consult with my GP or Consultant prior to receiving a treatment.

***\** It is your responsibility and not that of the therapist to consult with your GP or Consultant.**

*Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Type of Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*