

Margaret's Reflections of HOPE

Informed Consent Discussion

"I'm a Usui Reiki Master Teacher practitioner, and a Life-Grief Mentor Coach.

My education and training of Reiki was through the Reflections of Light by Ann Mort in Ocean, New Jersey. I received Reiki I, Reiki II, Reiki III, and Reiki Master Teacher through Reflections of Light.

My education and training of Grief Mentor Coaching was through Dr. Randin Brons and Express Coaching in 2014. I also completed the Death and Grief Studies through Dr. Wolfelt and the Center for Loss in Colorado 2016.

Explanation of Modality(s): Reiki is a complementary healing art that uses hands off the body to harmonize the energy pathways of the body to promote overall health and wellbeing.

Medical Care & Advice: The sessions are not a replacement for obtaining medical advice from your physician or therapist. I encourage to use Reiki, energy work, chakra healing and grief mentoring as a means of self-care, and to be used in addition to your normal medical routine.

No Guarantees & Warrantees: I cannot guarantee that you are going to feel better, nor what the outcome will be. However, I can tell you that other clients reported an overall sense of peace. Energy work is safe for everyone, children, pets, and adults.

With grief mentoring, I cannot guarantee that you will feel better, nor what the outcome will be, however, I can help you with a non-judgment atmosphere. I will create a safe space that will allow you to move your grief to mourning and holding onto hope as you do so.

Session Details, Including Risks/Benefits Reiki: You will remain fully clothed. I will hover my hands over your body in various areas. I will NOT touch you, not even light touch. You may experience tingling, heat, coolness, and sometimes a discomfort. If you do feel a discomfort, please let me know. But, many people experience a sense of deep relaxation and may even fall asleep. If you need to interrupt me for any other reason, such as going to the bathroom, you can do that. After the session, you may feel light-headed getting up from the table. I can assist you up from the table if you wish. For the next few days you may experience thirst, headache, and sometimes hunger. After the first 48 hours, most people feel refreshed, calm and with more mental clarity and better sleep patterns. Some may experience a few days of feeling more tired in the evening. This is the body's natural response to healing.

Salt (Halo) therapy is not intended to diagnose, treat, or cure. Please know, it is your responsibility to consult your primary care physician or appropriate, licensed health care practitioner for all your health concerns. You understand that no representations, claims or guarantees are being made as to any medical therapeutic benefit.

My TEAM and Recommendations- I have created a team of partners who feel the same about overall health that I myself practice. For your physical being, I may recommend you practice yoga, or we may take “our sessions” for a walk. This is to benefit you and your physical being. For your emotional and mental being, I may recommend you seek therapy through a licensed therapist, psychologist or any licensed health professional. This is to benefit you and your mental, and emotional being. I may recommend you speak to someone for education on financial freedom. This is to benefit you and your financial being. I may recommend a spiritual journey or retreat. This is to benefit you and your spiritual being.

These are recommendations to achieve the best you, you can be. There are no guarantees. Any costs that accrue outside Margaret’s Reflections of HOPE is sole responsibility of the client and the 3rd party.

Feedback/Questions: “Do you have any questions before we begin?”

INFORMED CONSENT FOR Margaret's Reflections of HOPE

I understand that the complementary energy work modality(s) provided to me uses light touch, hands off-the-body, and/or exercise(s)/technique(s) for the basic purpose of relaxation, relief of tension, balancing the energy flow in the body, and support of overall well-being. I hereby voluntarily give consent for

Margaret Pilon of Margaret's Reflections of HOPE,

to perform such wellness assessments, examinations and techniques, which may be recommended to me. The complementary modality(s) recommended to me includes:

Reiki, Chakra Balancing, Grief Mentoring, Life Coaching and Halo Therapy.

I understand and believe that the body has the ability to heal itself. Long-term imbalances in the body sometimes requires multiple sessions to achieve the level of relaxation necessary to bring the mind/body into balance. I understand this requires my commitment, and I am willing and open to receive the full benefits of recommended modalities and self-care instructions.

It has been explained to me that the practitioner(s) is not state licensed or registered in the modality(s) recommended to me. It has also been explained to me that the practitioner is Usui Reiki Master Teacher and Grief Mentor. I acknowledge that the practitioner(s) is not a physician and does not diagnose any physical or mental illness or disease. I clearly understand that these services are NOT a substitute for a medical examination, nor do they interfere with the treatment of a licensed healthcare professional. It is recommended that I visit my personal physician or licensed healthcare professional for physical and/or psychological ailments that I may experience. I acknowledge that no assurances or guarantees have been promised to me as result of any session or treatment. I acknowledge that with any session, there can be risks and benefits and those risks/benefits have been explained to me. Possible risks include, but are not limited to, lightheadedness and/or discomfort after the session. Possible benefits include, but are not limited to, more energy and/or a feeling of well-being. I understand that it is my responsibility to inform the practitioner of any discomfort I have during the session(s). I assume the risks, and will not hold the practitioner(s) liable for any risks associated with wellness assessments/consultations, complementary modality(s) sessions, workshops and/or classes.

I acknowledge and understand that the practitioner(s) must be made aware of my existing medical conditions. I have completed my health history form provided to me and disclosed to the practitioner(s) all of those medical conditions/symptoms affecting me. It is my responsibility to keep the practitioner(s) updated on my medical history and condition(s). The information I have provided is true and complete to the best of my knowledge.

I understand that a record(s) may be kept of the sessions, and that this record(s) is confidential and will not be released without my written consent or that of my legal

guardian, or as required by state and/or federal laws/regulations. I authorize my practitioner(s) to release or obtain information pertaining to my condition(s)/symptom(s) and/or treatment to/from my other caregivers or third party payers, only when necessary and only with a prior written request or as required by state/federal laws/regulations. Records will be retained according to state/federal requirements.

“I hold harmless Margaret’s Reflections of HOPE, LLC and all its employees, from any and all claims I may have against them due to my participation in salt (halo) therapy, reiki, and grief mentoring. I knowingly, voluntarily, and expressly assume all risk of participation in all models of healing and agree not to bring any legal claim against any of the Released Parties based on such participation.”

I have read the above noted consent, understand it, and have had the opportunity to ask questions. By signing this form, I confirm my consent to sessions and intend this consent to cover the sessions discussed with me and such additional sessions as proposed by my practitioner(s) from time to time, to deal with my symptoms for which I have sought advice. I understand that at any time, I may withdraw my consent and sessions/modalities will be stopped:

Client Name
(Print): _____

Signature of
Client: _____

If Client is a Minor Print Child’s
Name: _____

Signature of
Guardian: _____

Date Signed: _____

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