Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

# Reiki Treatment Informed Consent

**PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT**

We would like to take this opportunity to welcome you to Lakeside Natural Health Centre. This clinic utilizes the principles and practices of Reiki treatment. Reiki Masters use this energy-based healing technique involving light touch to help support the body. Reiki re-establishes a normal energy flow or ki (life force energy) throughout the body, which in turn can enhance and accelerate the body's innate healing ability.

The treatment and advice provided to you by the Reiki Master is not being provided in place of, or to the exclusion of, any other treatment or advice that you may now be receiving, or may in the future receive, from a physician, surgeon, or any other licensed health practitioner. It is your responsibility to inform your Reiki Master of any pre-existing medical conditions, injuries or disease of which you are currently aware of. It is your right and responsibility to inform the Reiki Master of your condition during the course of your treatment.

Privacy of your personal information is an important part of providing you with quality Reiki treatment. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. Our privacy protocol complies with privacy legislation and standards set out by the Government of Ontario.

I understand that a confidential record will be kept of the Reiki services provided to me. This record will be kept confidential but if required, I understand that my Reiki Master may discuss my case confidentially with other healthcare providers.

With this knowledge, I voluntarily consent to Reiki treatment. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Client Name (Please print name): ____________________________________________

Signature of Client or Guardian: ______________________________ Date: ____________

Reiki Master Name: ______________________ Reiki Master Signature: ____________________

The vision of Lakeside Natural Health Centre is to provide true integrative health care. Given our commitment to this best-patient practice, we will communicate with your other practitioners at our clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.
I welcome professional dialogue regarding my case between members of my health care team at Lakeside Natural Health Centre (please circle): Yes / No
Signature: ____________________

# Reiki Treatment Intake Form

Please complete both sides the following form to provide us with the background information we require to ensure you receive comprehensive care.

## Contact Information:

| | | | |
|---|---|---|---|
| Name | ____________________ | Occupation | ____________________ |
| Date of Birth | M________D________Y________ | Work # | ____________________ |
| Gender (circle) | Male / Female Age________ | Cell # | ____________________ |
| Home # | ____________________ | Emergency Contact | ____________________ |
| Address | ____________________ | Emergency Contact # | ____________________ |
| | ____________________ | Parent or Guardian Name | |
| Email | ____________________ | (If under 16 years) | ____________________ |

**YES / NO Can we send you our monthly newsletter and new event listings via email? Your email address will not be shared.**

**How did you hear about Lakeside Natural Health Centre?** ____________________

## Health Care Providers:

Medical Doctor ____________________ Specialist ____________________

Phone # ____________ Fax # ____________ Phone # ____________ Fax # ____________

## General Information (please circle):

What are your goals in receiving Reiki treatments? ____________________

Have you received Reiki or energy work before? YES / NO

If yes, please describe: ____________________

____________________

Are you currently being treated at this time?: YES / NO

If yes, please describe treatment plan and practitioner(s): ____________________

____________________

Please list any serious past or present illnesses or diseases (e.g. cancer, asthma, reflux, etc.): ____________________

____________________

Do you have any experience with the following? (please circle all that apply):

Yoga Meditation Biofeedback Shiatsu Tai Chi Other (please list): ____________________

## Billing Authorization:

### Credit Card on File:

Client's Name: ____________________ Name as it appears on the credit card: ____________________

Type of credit card (please circle): MasterCard / Visa Card #: ____________________

Expiration Date (month/year): ____________________

### Cancellation Policy:

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours' notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with our clinic policy.

I, ____________________, authorize Lakeside Natural Health Centre to process the above credit card as "Signature on File" for any balance due on my account past 30 days and for any appointments not cancelled in accordance with Lakeside Natural Health Centre's cancellation policy. I understand that a receipt will be promptly sent to me upon any charges.

Patient / Cardholder's Signature: ____________________ Date: ____________________