Therapy Roots, LLC
Liz Crawford
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therapyrootsllc.org

DISCLOSURE/CONSENT

Please thoroughly read the following paragraphs and then initial each paragraph after reading.

_____ I understand that the therapist does not diagnose illness, disease, or any other physical or mental disorder. In addition, the therapist does not prescribe medical treatment or pharmaceuticals. It has been made very clear to me that the bodywork provided includes techniques that are hands-on in nature and that my or my child's service will include hands on touch techniques.

_____ I understand that Craniosacral Therapy is considered to be a contraindication for recent injuries to the head and neck, i.e.; recent whiplash, any recent fracture to the base of the neck, concussion, or hemorrhage and state that I am not currently experiencing any of these conditions.

_____ It has been made very clear to me that craniosacral and myofunctional therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

_____ Because the therapist must be aware of existing physical conditions, I have stated all my known medical conditions above and take upon myself to keep the therapist updated on my physical health. Further, I release Liz Crawford from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

SERVICE AGREEMENT:

Please thoroughly read the following paragraphs and then initial each paragraph after reading.

_____ CANCELLATION POLICY: I understand that each appointment I have scheduled is very important, either for my own treatment process or that of another who could potentially fill the time slot. **I agree to notify Liz Crawford within 24 hours if I need to cancel an appointment. If I am unable to this, I understand that I will be responsible for payment for the scheduled time**

unless Liz is able to fill the appointment time. I have read and understand this cancellation policy.

_____ I understand payments are due at the time of service. Payments should be made by credit card, debit card, venmo, check, or in cash. These fees do not include MN Sales tax, which will be added at the time of service to all credit and debit card payments. I understand that these services are not billable to medical insurance and I am responsible to pay all balances. I understand if Liz Crawford is unable to collect payment for services, my account will be turned over to collections. If I want a Super Bill to submit to insurance, I will request a Super Bill at time of service.

I have completed the Intake information accurately and have read, understand, and agree to the terms and conditions listed above in the Disclosure/Consent and in the Service Agreement areas as well as acknowledge that if I have received, read, understand, and agree to the Complementary and Alternative Health Care Client Bill of Rights.

Print Patient Name: _____

Signature_____ Date_____

Self or Parent/Legal Guardian

If applicable:

I _____, as the parent/guardian of _____ herby provide my informed consent for the statements and information contained within this form to apply to and govern the treatment and care of my child's (named above) craniosacral and body work treatment, and/or myofunctional therapy. I acknowledge that I have read and understood the contents of this form and willingly give my consent on behalf of my child.