Informed Consent

By signing below, I hereby voluntarily consent to Biodynamic Craniosacral and Polarity Therapy for the noted purposes including assessments, examinations and treatments, which may be recommended by my therapist, Cynthia Schultz.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that Craniosacral Therapists and Polarity Practitioners are not primary care providers. I clearly understand that Biodynamic Craniosacral Therapy is not a substitute for a medical examination. I acknowledge that no assurance or guarantee has been provided to me as to the results of a therapy treatment session or series of sessions. I acknowledge that with any treatment there can be risks and those have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical and life conditions. I have disclosed to the therapist all of those medical and life conditions affecting me. It is my responsibility to keep the therapist updated on my medical history and any life conditions that may affect my treatment. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist, Cynthia Schultz, to release or obtain information pertaining to my condition and/or treatment to/from my other caregivers.

_____	_____
Primary Caregiver	Phone
_____	_____
Other	Phone

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment with me and such additional treatment as proposed by my therapist from time to time, to deal with my condition for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand that there will be a missed appointment charge as the day and time have been set aside specifically for me. I understand that without 24-hour notice of cancellation, except in cases of illness, emergency, or inclement weather, full payment will be due.

_____	_____
Signature of Client	Date
_____	
Print Name	
_____	_____
Signature of Therapist	Date

Cynthia Schultz RN, BCST, APP
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