

Client Agreements

I understand that the information divulged during sessions is **confidential** and that the practitioner will protect my privacy in accordance with all applicable laws.

I authorize the practitioner's office to contact me via the contact information I provided on my intake form (or leave messages as necessary) for reasons related to my continuing care (for example: appointments, requested consultations with a physician, etc.).

I know that **I am responsible for my own health and actions**. Shiatsu and adjunct therapies are only tools I employ to help me, and I initiate services here with this in mind.

I understand that **I will pay for my sessions at the time services are rendered**. Cash, cheque, and credit cards (MasterCard, Visa, Discover, American Express) are acceptable forms of payment. There will be a **\$30.00 fee if your bank returns your cheque**.

Rates may change without notice. Be sure to **ask your practitioner** when scheduling your appointment what the rate is currently.

I agree to **reschedule and/or cancel my sessions at least 24 hours in advance** of my schedule appointments by leaving a voice message at 800-680-8353 and **if I fail to do so or don't show for my session, I will pay the complete session fee**. When an appointment is scheduled, that time is reserved for you. If I arrive late, we will work through to the end of the scheduled time, and the fee will not change. If the practitioner is late, I will receive the full amount of time for which I was scheduled.

I understand **my practitioner is not a doctor or licensed psychotherapist**. The care provided is directed at relieving tensions and imbalances in the client's nervous, structural, energetic, and chemical systems. I recognize that (a) no claims are made for Shiatsu or adjunct therapies, nutritional or dietary recommendations to treat or cure any medical condition (b) all information is given for educational purposes only (c) there is no implied or stated guarantee of success of effectiveness of any specific treatment plan or guidelines (d) I am free to act on or disregard the recommendations of my practitioner as I so choose. Certain medications and social habits may decrease the beneficial effects of Shiatsu and related therapies. These include but are not limited to the use of alcohol, tobacco, steroids, painkillers, stimulants, caffeine, antidepressants, psychopharmaceuticals, and illegal drugs.

I understand that **sexual intimacy is never appropriate** with my practitioner.

I, _____, certify that I have read and understood the statements
(print name)
above. I also certify that I have informed my Shiatsu therapist of all known physical, mental, and medical conditions and medications, and that I will keep them updated on any changes.

Signature: _____ Date: _____