The Healing Team: Counselling and Guided Meditation Consent Form

Name: (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell phone or evening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, Province, Postal Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate which services you would like to receive. Services can also be combined.

Reiki Session □ Distant Healing □ Counselling □

Guided Meditations □ Past Life Regression □ Manifesting □

Please fill out the following sections:

Physical

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Emotional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Mental/Spiritual

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Are you sensitive to perfumes or fragrances? Yes □ No □

**Privacy and Confidentiality**

Everything that a client discloses to their counsellor is private and confidential. The instances when private information is disclosed to an outside source are: a) if it becomes evident that you are planning on harming yourself or another person, or b) if you share that a child under 16 years of age is being harmed and/or/abused. In these situations, your counsellor may break confidentiality to make sure that everyone stays safe. Whenever possible your counselor will make an effort to involve you in getting help to ensure safety. Should you refuse and your counselor feels there is a risk to you or the child, they will need to notify the appropriate authorities. Another instance when confidentiality may be breached is if the court presents us with a subpoena demanding your records. This is a very rare situation, but we need to inform you that we would have to abide by the law and release the records to the court. Otherwise your records and information will remain confidential and we will not release any information without your written and clearly stated consent.

**Record Keeping**

Your counselor keeps your records to maintain professional standards and provide you with an optimal service plan. Your records will be treated as strictly confidential and will be stored in a safe place. These records are kept for a minimum of seven years and at the time when established professional standards permit, they will be shredded/destroyed. No one can access your record unless a) you give written consent for your file to be shared, b) you ask in writing to view your records, c) the courts subpoena your record in the rare circumstances when they have been informed that you have used our services.

**Cancellation Policy**

Clients are expected to give 24 hours’ notice for cancellation or rescheduling of their appointment by phoning (647) 669-0497 (cell) and leaving a message. People are asked not to email with less than 48 hours’ notice in case the message is not received. This process allows the therapist to schedule another client.

**INFORMED CONSENT FOR COUNSELLING AND GUIDED MEDITATIONS/REGRESSION**

Please thoroughly review this form with your practitioner/counsellor before signing it.

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read the program information and confidentiality sections/documents and I completely understand the issues of informed consent. I have had the opportunity to consult and clarify with my counsellor any of my questions or concerns, therefore I have made the informed choice to freely participate in counselling, guided meditations and past life regressions with Stephanie Norwich, M.Ed. (Counselling), Reiki Master Instructor. The following signature of consent is valid for counselling and guided meditations, including past life regressions for the remainder of the calendar year.

Your name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness (signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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