**Past Life Regression Responsibilities and Liability Release:**

I understand that this technique is non-medical in nature and it is my responsibility to consult my regular doctor about any changes in my condition or changes in my medication.

1. I am willing to be guided through relaxation, visual imagery, hypnosis, and/or stress reduction techniques.

2. I understand the above modalities are not substitutes for regular medical care and I have been advised to consult my regular medical doctor or health-care practitioner for treatment of any old, new or existing medical conditions.

3. I understand that change is my own responsibility. I understand that ALL HEALING IS SELF HEALING and that Julie is only a “facilitator” in the process of helping me to solve my own problem(s). It is my responsibility to be open and honest, provide accurate feedback and be forthcoming with details and information that may help me achieve my own successful outcomes.

4. I understand that our session will be digitally recorded for my later use. I also understand that in these types of metaphysical sessions, the energy in the room can affect the equipment and/or recording, resulting in static or blank recordings. (This is quite rare, but it does happen occasionally.)

5. Except in the case of gross negligence or malpractice, I, or my representative(s), agree to full release and hold harmless Julie Doray from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

Client (Print full name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Special Use of Information:**

I understand that my name and personal information will be kept completely confidential, unless expressed otherwise by me.

I understand that I may share my recording and information in any way that I am personally comfortable.

I understand that often in sessions, universal information is provided through the client to benefit all of humanity. I agree to allow Julie Doray to share this information and any accompanying story on video, audio, or in written form in blogs or books as long as my name and all personal and relevant details are omitted or changed.

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information provided on this form is strictly confidential. It will only be seen by me and retained for my own personal records. Please copy/print this document, answer questions, sign and date, and email the completed form back to me prior to your session. If that is not possible, you can sign the form the day of your session.

Please always feel free to email me with any additional questions you may have prior to or after your session.

Thank you kindly. I am very excited to be able to work with you in the near future.

***Julie Doray***

QHHT Practitioner

Juliedoray1@gmail.com

850-319-0447