DISCLOSURE STATEMENT as Required Under SB-215 For Complimentary and Alternative Health Care Practitioners in Colorado

Practitioner’s Name: Candace Uvalle

Business Name: Sacred Awakenings Healing Arts

Practitioner Address: 1165 Acadia Cir, Erie, CO 80516

Practitioner Phone Number: 303-550-8050

As a Complimentary and Alternative Health Care Practitioner, I am not licensed, certified, or registered by the state of Colorado as a health care professional. I am not a licensed medical/mental health physician and do not diagnose, treat or prescribe remedies for the treatment of disease. The services that I perform, whether in person, by phone, on-line, by mail or a digital conference meeting are at all times restricted to complimentary and alternative health care services intended for the maintenance of the best possible state of health. I am prohibited from performing surgery or any invasive procedure, administer or prescribe x-ray or any other medically-based testing, prescribe prescription drugs, use general or spinal anesthetics, administer ionizing radioactive substances, use a laser or any other device that punctures the skin, perform enemas/colonics unless board certified, practice midwifery, practice psychotherapy, perform any chiropractic services including spinal manipulations, practice optometry, directly administer medical protocols to a pregnant woman or a person who has cancer, practice dentistry, set fractures, practice massage therapy, provide a conventional medical disease diagnosis or recommend the discontinuation of a course of care recommended by a licensed, health care professional. I am also prohibited from treating children less than two years of age. If treating children between the ages of 2-18, I must have written, signed consent of the child’s parent of legal guardian.

Candace Uvalle, as a Reiki practitioner, provides Reiki services through Sacred Awakenings Healing Arts. She does not diagnose illness, disease, or any other physical, mental, or emotional disorder. As such, she does not prescribe medical treatment(s) or medication(s), nor does she perform any spinal manipulation or massage therapy. Any and all conversations during the client’s session related to their medical condition or history are kept under strict confidentiality.

My professional degrees, training, experience, credentials, and qualifications are as follows:

-Master of Crystology Certification

-Level 3 Usui Master Reiki Practitioner Certification

-Master Teacher Shamanic Reiki Certification

-State of Colorado Licensed Special Education Teacher K-12 and General Education K-6

I carry liability insurance applicable to any injury caused by an accident or omission in providing complementary and alternative health care services. A copy of this disclosure statement will be kept on file for at least two years after the client’s last date of service.

\*As my client, during our Reiki session, should any information arise that is applicable or related to a medical condition that you are currently under medical care for, you should discuss this with any related health care provider, such as but not limited to Primary Care Physician, Obstetrician, Optometrist, Dentist, Cardiologist, Pediatric Health Care Provider, Gynecologist, Oncologist or other Board-Certified Physician.

**Adult Client Information and Signature:**

Name of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of First Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client (Indicating the client has read and understands the terms of service)**

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**For treatment of children ages 2-18 years (For Initial and Future Reiki Sessions):**

Name of Child ages 2-18 years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of Parent or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address of Parent or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of First Visit for child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_