

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, by my own free will, sign this waiver and accept all risks and I am perfectly aware that **Susan Rose** will be the practitioner conducting the therapy sessions associated with hypnosis. **Susan Rose is NOT a licensed Physician, NOR is she a licensed Psychiatrist and she CAN’T diagnose NOR treat any type of physical or mental disorders.** I fully understand that these hypnosis sessions are solely for educational and/or emotional enrichment. I also understand that any suggestions made during any session are part of a personal motivational and educational goal and it’s only of informational character. **Susan Rose DOES NOT pretend to be a licensed professional in Medicine or in any medical field and he is NOT a Mental Health specialist.**

**I understand that there are various techniques which may be used by the practitioner, including but not limited to Quantum Healing Hypnosis Technique (QHHT), Soul Regression Therapy (SRT), and Introspective Hypnosis**

**With this document, I waive any claim to personal injury liability that may be the end result of any hypnosis therapy session.** I also agree that **Susan Rose** assumes **NO** responsibility for the results of this therapy process, **NOR** does she guarantee its final outcome or effectiveness.

**I certify that I am a competent adult of legal age and I assume all risks and complete responsibility in the final outcome of this therapy.** I am also voluntarily signing this consent form with my full legal name. This waiver and acceptance of risk is effective as of today and it can’t be revoked, altered, modified, annulled or invalidated, without the prior written consent of **Susan Rose**.

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_**

**Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Full Name of Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent or Guardian**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(If the Patient is underage, the Parent’s or legal Guardian’s signature is required for legal consent of treatment).**

**CONSENT TO THE CONTENTS OF THIS DOCUMENT**

By signing this document, I understand that I have carefully read and understand all the clauses of this document and I make the commitment to abide by all its clauses. My signature also means that I will have the opportunity to request clarification of any doubts that I may have about this subject and that I will be provided with answers in a satisfactory manner.

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION TO RECEIVE HYPNOSIS TREATMENT:**

**YES\_\_\_\_ NO\_\_\_\_\_ PATIENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**