**Client Agreement for Services, Disclosures &**

**Consent for Treatment for Remote Healing Touch Sessions**

**Practitioner Name and Credentials:**  Rita Gigliotti – Healing Touch Student (Levels 1, 2, 3)

**Practice Location:** Zoom or Facetime

**Contact:** [rita@ritagigliotti.com](mailto:rita@ritagigliotti.com) 703-835-7875

**Definition of Healing Touch**

Healing Touch is a holistic integrative therapy intended to clear, balance and energize the human energy system in order to facilitate physical, emotional, mental and spiritual self-healing.

The trained practitioner uses gentle light touch with heart centered intention. Healing Touch is intended to complement and not replace any prescribed medical care. Practitioners do not diagnose conditions or prescribe treatment.

**Session Information**

Remote Healing Touch services involve the use of secure interactive videoconferencing devices and equipment that enable the practitioner to deliver services to the client virtually when both are located at different sites.

Sessions are 60 minutes long.

The fee per session is $50.

Practitioner is not a provider for any insurance carrier and will provide an invoice for sessions upon request.

1. I understand that the same standard of care applies to a remote session as applies to an in-person visit.
2. I understand that the laws that protect privacy and the confidentiality of personal information apply to remote sessions.
3. I understand that I will not be physically in the same room as the practitioner. I will be notified of, and my consent obtained for anyone other than the practitioner to be present or work with me.
4. Risks to Confidentiality: I understand that as remote sessions take place outside of the practitioner’s office, there is potential for other people to overhear conversations if the I am not in a private place during the session. The practitioner will take reasonable steps to ensure privacy. It is my responsibility to find a private place for the session where I will not be interrupted. I also understand that it is my responsibility to protect the privacy of our session on the device being used.
5. Technology Issues: I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies. If it is determined that the video conferencing equipment or connection is not adequate, I understand that either the practitioner or I may discontinue the remote session and make other arrangements to complete the session.
6. Risks to Confidentiality: I understand that as remote sessions take place outside of the practitioner’s office, there is potential for other people to overhear conversations if the I am not in a private place during the session. The practitioner will take reasonable steps to ensure privacy. It is my responsibility to find a private place for the session where I will not be interrupted. I also understand that it is my responsibility to protect the privacy of our session on the device being used.
7. Technology Issues: I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
8. If it is determined that the video conferencing equipment or connection is not adequate, I understand that either the practitioner or I may discontinue the remote session and make other arrangements to complete the session.

**Appointment Cancellation Policy**

I agree to give a 24-hour notice if it is necessary for me to cancel an appointment. My practitioner reserves the right to charge me for the session if sufficient notice is not given.

**Confidentiality**

All client information and records are treated in a confidential manner and no information will be released to anyone without my prior written consent, except in situations governed by law.

**Disclosures**

* Healing Touch practitioners do not diagnose conditions or prescribe treatments.
* No specific claims will be made by the practitioner regarding results from the Healing Touch sessions.
* Treatment goal(s) will be mutually identified as part of the assessment and clients have input in the goal setting process.

**Practitioner Liability Insurance**

Healing Touch Professional Association in conjunction with Tokio Marine Specialty Insurance and Philadelphia Consolidated Holding Corporation (PHLY).

**Hold Harmless Clause**

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless, Practitioner Name, 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 Consent for Treatment**

\_\_\_ *(initials)* I have read this document and been given the opportunity to ask questions regarding this document and Healing Touch sessions.

\_\_\_ *(initials)* I take responsibility to inform my practitioner of any changes in my health status.

\_\_\_ *(initials)* Yes, I give permission for light touch.

**Signature**

Client or Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Printed Name if Applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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