# CLIENT CONSENT FOR ENERGETIC SESSION

I _____ (CLIENT), have received information and understand the possible Energetic techniques, such as, Healing Touch, Energetic Transformation, Polarity, Acupressure, Biogenesis, Holographic Healing, other energetic modalities and channeling used in this session are gentle, complementary energy based approach to health and healing that can assist my body in its natural ability to heal. I fully acknowledge and understand that this is accomplished through the use of noncontact touch.

Kathy Stubbs does not guarantee a cure or prevention of disease and makes no claims in this regard. It may be said, Kathy Stubbs is an instrument of divine healing energies which act as a catalyst for your own self-healing. Kathy Stubbs is the vessel/practitioner and the client is the actual healer. There may be expectations of the healing work. Many clients experience life-changing occurrences after one session, but the likelihood no matter what healing modality is used, there is no guarantee, nor that one treatment will suffice. Healing may take some time especially if the client is resistant to the work. This work further explores physical, mental, emotional, and spiritual ties to past lives and determines if there is a connection with the present life.

It has been explained to me, that these energetic techniques are complementary therapy not intended to replace any currently prescribed medical treatments as ordered by my physician nor any other medical care I have I may be advised to seek by them.

I have been informed that the practitioner will neither diagnose nor prescribe for any condition that I might have nor does she make specific claims regarding results from the sessions that I receive.

I have been informed that Kathy is not licensed to practice medicine in this state. I have been encouraged to consult a licensed medical practitioner for any physical or mental complaints I may have.

Some of the indications for a session include, but are not limited to:

- Reduction in pain, anxiety and stress
- Decrease in nausea
- Preparation for medical treatment and procedures and to manage side-effects
- Support during chemotherapy
- Support the body’s natural healing process

I have been informed that all client information and records are treated in a confidential manner. My experiences during these sessions are confidential subject to the usual exceptions governed by the State or federal laws and regulations.

I have read and accept the Terms and Conditions and Privacy Information on the jeremeil.com website.

My questions have been answered to my satisfaction regarding Kathy's background and what I might expect from this session.

I give my consent to receive this treatment from Kathy Stubbs.

Patient Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____