CONSENT FOR ENERGY TREATMENT

WITH DR. JULIE HOLLINGSWORTH, PHD
DOCTOR OF ESOTERIC STUDIES

Name _____ Date _____

The purpose of this consent form is to explain my intent as well as what you can expect of an energy treatment session. My belief about healing is that each of us is our own healer; that healing comes from surrendering to the power within. I work with energy, angels, and the light (that some people choose to call God). I get information from the other side as I work with people and it is nothing to be afraid of. This is called consciousness and it is a way of living that allows people to be free and realize their purpose and joy in this world. I hold a PhD in Esoteric Studies which means ancient and hidden knowledge. I use this in my practice and the results are beautiful. I am here to assist you in waking up to be who you really are.
If at any moment during the session you are uncomfortable, please inform me immediately. Self-care is an integral part of your healing process.

During your session we may discuss the major stresses in your life, belief system, childhood, health history, habitual thoughts & patterns, and other issues that have influence on your emotional, mental, spiritual, and physical well-being. Confidentiality is assured.

At all times your healing is your responsibility. I am available to be your committed listener, your ally, and your mirror in this process. I do not advise you to discontinue any medical treatment you may be receiving. My work is intended to be in harmony with any other healing work that you undertake, including traditional Western medicine. Please feel free to discuss our work with your doctor. I am not a physician, and therefore do not diagnose disease or prescribe drugs. I serve as an Energy Practitioner.

I have read & understand the above (initials) _____ date _____

I, understand that Julie Hollingsworth does not diagnose illness, disease, or mental disorder. Nor does she prescribe medical treatment or pharmaceuticals. It has been made clear that energy treatment is not a substitute for medical examination or diagnosis and that it is recommended that I see an M.D. for any physical or mental ailment. With this in mind I agree that Julie Hollingsworth cannot be held liable for any problems that might arise that I think could be attributed to the energy treatment session. I have stated all of my known medical conditions and vow to keep Julie updated on my physical, mental, and emotional health. I attest that I understand the nature of the treatment and freely elect to receive treatments. I release Dr. Julie Hollingsworth, Ph.D, from any and all claims of malpractice, non-disclosure, or lack of informed consent.

Signed in agreement _____ Date _____

Initial here _____ to give your consent for me to consult with your physician and/or my peer group of therapeutic professionals regarding your case.