Reiki Client Information Form

_____ New Client _____ Returning Client

Name: (Please Print) _____
Address: _____
City, State, Zip: _____
Phone: _____
Email: _____
DOB/Age: _____ Occupation: _____ Lifestyle: _____
Emergency Contact: _____

Are you currently under the care of a medical practitioner: ___ Yes ___ No
If yes, practitioner's name: _____
Current medical conditions or devices: _____
Are you currently taking medications: ___ Yes ___ No (please list)
_____

Have you ever had a Reiki session before: ___ Yes ___ No
If yes, when was your last session? _____

Reason for session:
___ Wellness ___ Relaxation/Stress Reduction ___ Emotional ___ Mental/Spiritual
___ Physical ___ Other (please specify) _____

Were you referred to us? If so, by who? _____

_____ *(initials) I acknowledge that I have received a copy of the COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS from Our Essential Journey, LLC as required by the State of Minnesota. I have read and understand the Client Bill of Rights, or it has otherwise been read to me. I have had a full opportunity to ask any questions I have about this document and my rights as a Client. I understand my rights as a Client.*

WAIVER / DISCLAIMER

As the recipient receiving the Reiki treatment, I understand that the Reiki techniques being provided promote a cooperative model to bridge holistic healthcare with traditional medicine. Reiki techniques are intended to enhance the healing process and do not replace traditional healthcare. I understand Reiki Practitioners do not diagnose, prescribe medications or perform surgery and that I should refer to a physician for traditional medical care for questions concerning specific illnesses. I understand that the Reiki Practitioner does not manipulate the body.

I understand and agree that I am solely responsible for consulting my physician in any case of physical, mental or emotional illness. I agree to keep my Reiki Practitioner informed of any changes in my condition as this could affect future treatments.

I acknowledge that the treatments described above, as administered by the Reiki Practitioner, are offered as an adjunct to, but not a substitute for, medical care.

I understand that the Reiki Practitioner is not a physician. I hereby waive all rights to cause any action against the Reiki Practitioner, or his/her assigns or beneficiaries, stemming from this statement. This waiver binds my agents, assigns and beneficiaries.

_____ _____

Client or Legal Guardian Signature Accepting Waiver Date

COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

Practitioner Name: Nancy Ellis
Business Name: Our Essential Journey, LLC
Business Address: Waconia, MN 55387
Business Phone: 952-201-9516

Degrees, training, experience, or other qualifications of Nancy Ellis, hereinafter referred to as the Practitioner:

Reiki Trainings and Attunements by Rachel Augusta from the Gutsy Grackle, LLC in Minneapolis, MN. Psychic Foundation Development instruction from Cindy Lehman in Minneapolis, MN. BES Bachelor Degree with concentration in Psychology earned from St. Cloud State University, St. Cloud, MN.

"THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.

Under Minnesota law, an unlicensed complementary and alternative health care Practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a Client desires a diagnosis from a licensed physician, chiropractor, or acupuncture Practitioner, or services from a physician, chiropractor, nurse, osteopathic physician, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the Client may seek such services at any time."

The Practitioner, Nancy Ellis, works independently and practices in various locations.

The Client has the right to file a complaint, in writing, directly with the Practitioner at the address listed above.

The Client may contact the Office of Unlicensed Complementary and Alternative Health Care Practice for any complaints.

Mailing address: P.O. Box 64882, ST. Paul, MN 55164-0882
Telephone: 651-201-3728 or FAX: 651-201-3839
Website: www.health.state.mn.us

Full payment is due at the time of service by cash, online payment programs such as Venmo, PayPal, etc or via credit card. See fee schedule for current rates and offerings. No insurance is accepted, and no insurance claims are filed by the Practitioner. Practitioner does not accept Medicare, Medical Assistance or General Assistance medical care.

Clients have the right to reasonable notice of changes to the fees, services, or policies of the Practitioner.

The Practitioner provides energy sessions based on what serves the Client's highest good at the moment. The energy sessions are individualized and focused on the Client needs, intentions and desires utilizing a variety of energetic modalities. The Practitioner does not diagnose, treat, cure, and/or prevent disease. The Practitioner does not manipulate the Client's body. The Practitioner does not predict the future. The expected outcomes of a session may include (but not limited to) energetic balance, spiritual growth, improvement of physical wellness, emotional clarity and/or a sense of peace.

Clients have the right to complete and current information concerning the Practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided.

Clients have the right to expect courteous treatment, free from verbal, physical, or sexual abuse.

Client records are confidential and will not be released, unless authorized by the Client in writing or as otherwise provided by law.

Clients have the right to access their own records maintained by the Practitioner's office, in accordance with Minnesota State Statute Sections 144.291 to 144.298.

Other energy services are available to the Client in this same community. These can be located by asking the Practitioner, or the provider who referred you to this Practitioner.

The Client has the right to choose freely among available Practitioners and to change Practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.

The Client has the right to coordinated transfer of your records when there will be a change in the provider of services.

The Client may refuse services or treatment, unless otherwise provided by law.

The Client has the right to assert any and all of the above-mentioned rights without retaliation from the Practitioner.

Minnesota's Freedom of Access to Complementary Care Law (Statute Chapter 146A) requires that you receive and acknowledge that you have received by your signature on this page, the above listed information prior to your treatment.

By signing below, I acknowledge that I have received a copy of the COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS from Our Essential Journey, LLC as required by the State of Minnesota. I have read and understand the Client Bill of Rights, or it has otherwise been read to me. I have had a full opportunity to ask any questions I have about this document and my rights as a Client. I understand my rights as a Client.

_____ _____

Client or Legal Guardian's Name Printed Date

_____ _____

Client or Legal Guardian's Signature Date

_____ _____

Relationship to Client Date

SUBMIT FORM

Electronic submission of this form affirms your acceptance.