Reiki Informed Consent and HIPPA Form

I hereby request and consent to Reiki treatment by _______________ (your name). I understand Reiki is used to treat a wide range of issues of the body, mind, and spirit. I have received no guarantees as to its effectiveness. I understand Reiki is a safe method of energy healing that has no known side effects, nor can it harm the body in any way.

I understand and acknowledge Reiki is not meant as a substitute for medical treatment, and my Reiki practitioner cannot and will not diagnose or prescribed. I also understand it does not interfere with traditional medical treatment. Reiki is a natural source of beneficial life force energy.

I understand that if I experience an emergency, a worsening of my health condition, or a new ailment or condition arises, I should consult a licensed physician.

I understand that staff may review my records, but all of my records will be kept confidential and will not be released without my written consent. I understand I have the right to request restrictions on certain uses and disclosures of my health information. By voluntarily signing below, I show that I have read carefully, or have had read to me, this form and understand its provisions. I have asked any questions about this form and the proposed services and have received satisfactory explanations.

This consent form covers the entire course of treatment for my present condition and for any future condition(s). I realize I am free to discontinue services at any time.

Payment & Cancellation Policy

Payment is required when treatment is rendered unless other arrangements have been made. You agree to be responsible for all charges accrued in this office.

If you need to cancel or postpone your session, call me at _________________ at least 24 hours in advance. Otherwise, you will be charged the full fee for the missed session unless due to illness and family emergency.

_____________________________________ _____________________________________

Printed Name of Patient Signature

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Date

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires health care professionals give their clients a Notice of Privacy Practices and that clients sign in acknowledgement that they received the notice. Your health information will be routinely used for treatment, payment, and quality monitoring, and your consent, or the opportunity to agree or object, is not required in the following instances:

- Information obtained by your practitioner will be entered in your record and used to plan the course of treatment.
- Your record will be used to receive payment for services rendered by the practitioner(s) at ___________________________.
- This office will use your health information to assess the care you received and compare your treatment outcomes to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide. In addition, the following disclosures are required by law and do not require your consent:
    - This office is required by law to disclose heath information to the Food and Drug Administration (FDA) related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
    - This office will release information to the extent authorized by law in matters of worker's compensation.
    - This office is required by law to disclose health information in response to a valid subpoena for law enforcement purposes, as required under state or federal law.
    - In the event that a member of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspect or clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.
    - This office will disclose your health information in cases of domestic violence. The following are considered routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, this office will request your authorization only when disclosure of personal health information is necessary to parties other than those referenced here.
    - Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

This office may send information to you about health-related issues that you may find useful. Only your name and address will be used. I acknowledge may voluntarily consent to treatment, and that I have received and understand this Notice of Privacy Practices.

Signature: ____