DIVINITY HEALING LLC (DIVINITY CENTER)

Liability Waiver and release

And

Informed consent to treat

for Personal Energy Consultations/Classes

I, _____, am here to inspire my own personal transformation. I take personal responsibility for my well-being and with respect for myself I gratefully accept control of my choices. My heirs, guardians, legal representatives, and I hereby and forever release, waive, and discharge any claims against, Divinity Healing LLC, Jyothsna Srigiriraju, and/or any of their associates or affiliates. I take full responsibility and am responsible for all liability for loss or injury incurred while in association with or applying energy techniques and information learned from Jyothsna Srigiriraju and/or any of their associates or affiliates.

I have carefully read this agreement and fully understand its content. I am aware that this is a waiver and release of potential liability and a contract between the above noted parties and myself. I understand that this contract is binding and acknowledge that I am signing this of my own free will.

Client Signature: _____ Date: _____

Printed Name: _____

Address: _____

_____

Day Phone: _____ Email: _____

Cell Phone: _____ Skype Address: _____

ENERGY HEALING MODALITIES
INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of energy healing modalities and treatments within the scope of the practice of Energy Medicine Practitioners on my (or on the patient named below, for I am legally responsible) by the Energy Practitioner named below, or another practitioner, working or associated with or serving as back-up for the Energy Practitioner named below, including those working as part of Energy Intuitive as listed below, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: Energy healing, Theta Healing ™, Soul Detective ™, Akashic Records, and Divine Grace. I will immediately notify my energy practitioner listed below of any unanticipated or unpleasant effects associated with any of the energy modalities applied.

I have been informed that energy medicine is a generally safe method of treatment, but that shifts in energy occur and may create some physical, emotional or spiritual side effects which may include physical tingling, feeling lighter energetically, mild fatigue, nausea, muscle soreness, headache, thirst, changes in relationships, shifts of perception, etc. I do not expect the energy practitioner to be able to anticipate and explain all possible risks and complications of energy treatment, and I wish to rely on the energy practitioner to exercise judgment during the course of treatment which the energy practitioner exercises a best and highest interest for healing, based upon the facts then known and for my best interest and highest good. I understand that results are not guaranteed.

I understand that all clinical information and records of energy healing treatments etc. will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of energy medicine and intuitive energy healing and other energy modalities, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of my energy treatments for my present condition and for any future conditions(s) for which I seek any energy healing modalities.

Client Signature: _____ Date: _____

(Or Patient Representative): _____
(Indicated relationship if signing for patient)