Healing Through Balance, LLC
214 Main Street, Box 451
El Segundo, California 90245

admin@healingthrubalance.com
310-322-1049

Bringing Balance to the Mind, Body, and Spirit

New Client Parental Consent for Minor Child

I, _____ request / give consent for my child, _____, to receive Energetic Healing services from Diana Christopher.

I understand and acknowledge that no guarantees have been made to me regarding the effect of Energetic Healing services.

I also understand and acknowledge that these services are not a diagnosis or treatment of any disease, that the State of California does not require Reiki/Energetic Healing practitioners to be licensed or hold any State certification, and that Reiki/Energetic Healing is merely an alternative practice used to balance my child's energy to promote his/her/their general well-being, enhance relaxation, and the reduction of stress

I understand that prior to my child's first Energetic Healing session I will receive a verbal explanation of a generic Energetic Healing session and that I may refuse any and all services on behalf of my child at any time during any Energetic Healing session I choose to allow him/her/them to participate in.

I understand that Energetic Healing is not a substitute for medical treatment or medications and that it is recommended that I also work with my child's Doctor/Primary Caregiver for any medical conditions she/he/they may have. I am aware that an Energetic Healing practitioner does not diagnose illness or disease and does not prescribe medications or supplements.

Has your child ever had an Energetic Healing session? Yes ☐ No ☐

If needed, is aromatherapy acceptable? Yes ☐ No ☐

Is your child currently taking any medications? Yes ☐ No ☐

If yes, please list all medications/drugs s/he has taken in the past 30 days:

_____

_____

Please note … this is important because the effects of some medications may affect energetic practitioners.

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Does your child have any metal implants in their body? If yes, please give the approximate locations.
Note: This is important for sound therapies.

_____

_____

I have read both the "*Office Policies for Energetic Healing Sessions*" and "*Statement of Rights and Responsibilities*" documents and agree with the information they contain.

If myself or my child experience any discomfort during any Energetic Healing session it will be immediately communicated to the practitioner so that the treatment can be modified or discontinued.

Child's Name (printed): _____

Signature of
Parent/Guardian: _____ Date: _____
Parent/Guardian
Name (printed): _____