Auburn Reiki Center

Northern California's leading training facility for Traditional Japanese Reiki

101 Orange Street, Auburn, CA 95603

Phone: 916-956-2181

www.auburnreikicenter.com

Reiki Client Information Form

(Please Print Clearly)

Name: _____ DOB: _____

Address: _____

City, State, Zip_____

Email: _____

Phone *(home)*: _____ *(cell)*: _____

Emergency Contact: *(name)* _____

(relationship) _____ *(phone number)* _____

Employer: *(name)* _____ *(phone)* _____

(address) _____

Are you under the care of a physician? __ Yes __ No Dr. name: _____

Address & phone: _____

Current Medications and dosage: _____

How did you hear about us? _____

Have you ever had a Reiki session before? __Yes __No Date of last session: _____

Do you have a particular area of concern? _____

_____

Are you sensitive to perfumes/fragrances? __Yes __No Are you sensitive to touch? __Yes __No

I understand that Reiki is a simple, gentle, hands-on energy technique that is used for stress reduction and relaxation. I understand that Reiki practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional. I understand that Reiki does not take the place of medical care. It is recommended that I see a licensed physician or licensed health care professional for any physical or psychological aliment I may have. I understand that Reiki can complement any medical or psychological care I may be receiving. I also understand that the body has the ability to heal itself and to do so, complete relaxation is often beneficial. I acknowledge that long term imbalances in the body sometimes require multiple sessions in order to facilitate the level of relaxation needed by the body to heal itself.

Signed: _____ Date: _____

Privacy Notice: No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.

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PRIVATE PAY OFFICE POLICY & MISSED APPOINTMENT AGREEMENT

Payment for each office visit is due and collected at the time of service.

I understand that if I am sent to collections for an outstanding bill, I will be responsible for any and all applicable collection fees, court costs and attorney fees which are incurred as a result of this action.

In addition, I understand that there will be a $85.00 charge for any missed appointments without giving 24-hour notice. I also understand that I will be held responsible for payment and that my insurance company *(if any)* will not pay for a missed appointment charge.

_____

Clients Name (please print)

_____ _____

Clients Signature Date