PLANT SPIRIT MEDICINE INFORMED CONSENT FORM

I understand that Plant Spirit Medicine is a form of spiritual healing in which no substances are prescribed or administered. I am aware that my Plant Spirit Medicine Healer builds relationship with Plant Spirits and calls upon them to restore balance and harmony.

I understand that Plant Spirit Medicine Healers 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 I should see a licensed physician or licensed health care professional for any physical or psychological ailment I may have.

I understand that Plant Spirit Medicine is a spiritual practice and does not take the place of medical care, but can be a part of a holistic approach or wellness program.

I understand further that there is no specific guarantee of any specific result. I acknowledge that long-term imbalances in the Body-Mind-Spirit sometimes require multiple sessions to bring the system back into balance.

Acknowledgement and Consent to Receive Healing

I have read and understand the above disclosure about the healing offered by this Plant Spirit Medicine Healer. I have discussed with the Healer the nature of the services to be provided. I understand that the Plant Spirit Medicine Healer is not a licensed physician, but a lay Spiritual Healer ordained by the Temple of Sacred Fire Healing. I understand that it is my responsibility to maintain a relationship for myself/my child with a medical doctor. I have consented to the healing offered by this Plant Spirit Medicine Healer and agree to be personally responsible for the fees incurred with the healing provided to me.

I hereby agree to release and hold harmless (Healer) from any and all claims or demands, including but not limited to claims or demands related to any physical, mental or emotional condition, present or future, arising from or associated with any services provided by (Healer) at any time.

Signed: _____ Date: _____

Indicate capacity to sign if other than client_____

Print Name: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____

Referred by: _____

Privacy Notice:
No information about any client will be disclosed to any third party without written consent of the client and parent or guardian if the client is under the age of 18.

Practitioner Signature: _____ Date: _____