THE CENTER FOR
Mind-Body Healing

Shelia Kuhn, SEP®
Somatic Experiencing Practitioner™
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INFORMED CONSENT & DISCLOSURE FORM

DESCRIPTION OF SERVICE

Somatic Experiencing® is not a substitute for psychotherapy, and I, Shelia Kuhn, am not a licensed psychotherapist. I am a *Somatic Experiencing Practitioner.* **Please initial here that you have read and understand this paragraph.** _____.

The modality I use to assist others in their healing processes, is a *body-centered, awareness based, modality*. *Somatic Experiencing* is a naturalistic approach to the resolution of post-traumatic stress reactions. *Somatic Experiencing* is body-centered and consists, in essence, of various mindfulness practices that help individuals to resolve stress and post-traumatic stress reactions. There are two forms of *Somatic Experiencing*: 1) Chair Work (as the name implies) is carried out with both client and practitioner sitting in chairs; 2) SE Touch, is carried out on the table.

LIMITATIONS

A Somatic Experiencing Practitioner does not diagnose or treat diseases. This work is not offered as a replacement or substitute for health care treatment with a licensed and qualified health care professional, but rather as an optional health care service. Shelia Kuhn is *not* a licensed health care professional. Please see your health care physician for diagnosis and treatment for any disorder or illness.

*****Responsibility lies with the client to seek medical advice and opinion from the client's primary or specialized care physician regarding regular assessment and routine monitoring of any medical condition or distressing symptoms.**

FEES AND CANCELED OR MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24-hours notice, you will be responsible for the full fee. **Please initial here that you have read and understand this paragraph.** _____

CONFIDENTIALITY

All information exchanged between practitioner and patient is held strictly confidential unless: 1) The client authorizes release of information with his/her signature; 2) The client presents a physical danger to his or herself or to others; 3) Child/Elder abuse/neglect are suspected. If the practitioner seeks a "2nd opinion" in the form of a case consultation with a more senior practitioner, the name of the client is not used and thus express, written permission from the client is not required.

My fee is $100 for a 60-minute session. I accept checks or cash and payment is due at the time of the session. **Checks must be made out to D&S Kuhn, Incorporated.** **Please initial here that you have read and understand this paragraph.** _____

REMOVAL AND DESTRUCTION OF CLIENT RECORDS: After a period of five (5) years from the completion of services, the practitioner may shred and destroy all records and copies related to Somatic Experiencing sessions with client.

ACKNOWLEDGEMENT AND CONSENT TO RECEIVE SERVICES: I have read and understand the above disclosure regarding the services offered by Shelia Kuhn. I understand that Shelia Kuhn is *not* a physician or a psychotherapist and that Somatic Experiencing services are not licensed in the state of California. I further understand that Shelia Kuhn is not trained to diagnose illness, make recommendations involving pharmaceutical drugs or surgery, or handle medical emergencies. I have consented to use the services offered by Shelia Kuhn and agree to be personally responsible for the fees in connection with the services provided.

AUDIO RECORDING:
Sessions will be audio recorded for the sole purpose of taking notes. **All audio recordings will be deleted/erased within 5 days.** These recordings are confidential and will only be used by Shelia Kuhn. I understand that I will receive sessions whether or not I agree to audio recording of sessions. I understand I have a right to withdraw consent at any time, including during a session. **Please initial here that you have read and understand this paragraph.** _____

I acknowledge and accept the above statements:

Name of Client (print):_____Date of Birth:_____

Address:_____

City/State/Zip:_____

Phone:_____ E-Mail Address:_____

Client Signature:_____ Date:_____
If client is a minor, please state your relation to the client and sign below as legal guardian:
Relation to client: _____

_____ _____
Parent/Guardian Name (Please Print) **Date**

_____ _____
Parent/Guardian Signature **Date**