Waves of Healing

INTAKE & AUTHORIZATION FORM

Date: _____

Name: _____

Email: _____

Address: _____

Phone: _____

Age: _____

Who referred you to Waves of Healing? _____

What physical and/or emotional issues would you like help with?

_____

_____

_____

AUTHORIZATION & ACKNOWLEDGEMENT

- I understand the techniques used in my session are not meant to diagnose, heal, cure, foretell my future, and or determine major life decisions.
- I understand the practitioner will be holding my arm underneath the wrist and or demonstrating tapping techniques using my hands.
- I understand in no way is this technique meant to replace medical professional and or mental professional help.
- I understand out of respect for the practitioner's time, I will be charged full price for my appointment if I cancel less than 24 hours of my appointment time. I also understand I will not be rescheduled until my cancellation fee is paid in full.
- I understand if I do a proxy appointment, an appointment where I am not physically present in the office. Payment is due the same day of service.

Patient Signature: _____