Sheila Ring Reed, LCSW, LLC

INFORMED CONSENT AND RELEASE AGREEMENT

Name of Patient: ____

1. I am requesting for Sheila Ring Reed, LCSW, LLC to provide the following services to my child / self: ____
____.

2. I am aware that these services require that I provide confidential health information regarding my child / self to Sheila Ring Reed, LCSW, LLC and any affiliated health care providers.

3. I am aware that each human body is different structurally and bio-chemically, and will react differently to the services provided. Accordingly, there is no certainty or predictability as to how my, or my child's, body might react.

4. I am aware that under no circumstances will Sheila Ring Reed, LCSW, LLC diagnose, treat, operate on or prescribe for any disease, pain, injury, or physical condition. Only licensed physicians may engage in such activities.

5. I understand that the services provided by Sheila Ring Reed, LCSW, LLC are not a substitute or alternative to proper medical care. I retain the responsibility for ensuring that my child / self is under the regular and continuous supervision of a physician.

6. I warrant and represent that my child / self is in good physical and mental health and condition, and have no ailment, disability, or impairment which might prevent him / her / me from receiving these services or which might be aggravated or activated by such services.

7. I warrant and represent that I have discussed my intention to participate in this program with my physician, have described its various components to the physician, and have obtained permission from said physician to receive these services. My

physician is of the opinion that participation in the program offered by Sheila Ring Reed, LCSW, LLC will not aggravate or activate any symptoms, illnesses, or disorders which my child / self may have. Nor would it be harmful, injurious, or detrimental to the health, safety, or well-being of my child / self by participating in this program.

8. I acknowledge that I am participating in this program of my own free will. Sheila Ring Reed, LCSW, LLC has not made any claim, promise, or guarantee regarding the effectiveness, usefulness, performance, or safety of this program.

9. I acknowledge that I have evaluated the advisability of my child's / own participation in Sheila Ring Reed, LCSW, LLC's program. I in turn take full responsibility for the physical, mental, and emotional transformations attained as a result of such participation. In consideration of Sheila Ring Reed, LCSW, LLC's consent to allow my child / self to participate in the program, I hereby agree for myself, my heirs, and assigns to hold Sheila Ring Reed, LCSW, LLC harmless from any and all liability arising out of my child's / own participation in the program or receipt of any services. I take full responsibility for any and all injuries or losses, and freely, knowingly, and voluntarily agree to assume all risks involved, if any, during the program.

10. I acknowledge that I have read the above nine (9) paragraphs. I full understand each and every one of them, and I freely and voluntarily agree to abide by all of these conditions as evidenced by my signature below.

DATE: ________________

Patient / Parent / Guardian name: ____________________________________

Patient / Parent / Guardian signature: _________________________________