Waiver

Expert Outcomes
Stephanie C. Shipper
sshipper@mindspring.com
(919) 572-2215

CLIENT CONFIDENTIALITY and INFORMED CONSENT

1. I fully understand that Stephanie Shipper is not an M.D., psychologist, MSW, but is a Certified NLP Trainer, Certified Hypnotherapist, Trained in Kinesiology (Touch for Health), and Certified in Havening (Amygdala DePotentiation Therapy). I am not here for any medical, diagnostic, treatment or therapeutic procedures. All services performed by Stephanie Shipper are restricted to education/ coaching/mentoring._____

2. I fully understand that Stephanie Shipper does not Treat, Diagnose, Hospitalize or Prescribe drugs/ remedies for diseases, nor does she do any services which require a license in this state. I understand if I need these services I am advised to seek them from properly licensed practitioners. In no circumstances am I advised to discontinue or ignore treatment or advice from licensed professionals._____

3. I understand and accept that all suggestions, information, and or education by means of discussion, muscle testing, or other means is purely educational and in no way constitutes a medical diagnosis or treatment._____

4. I understand that I am the person most responsible for my own health or well being. Should I be uncomfortable with any suggestions made, I am free to disagree and refuse suggestions and seek a better solution from within my own frame of reference._____

5. I have solicited Stephanie Shipper's advice in good faith, exercising my free will and following the dictates of my own conscience, which allows me to select what I understand is most beneficial to my health._____

6. I fully understand that if I am under the care of medical or mental health licensed professionals for the same or related problem, and I am on a prescribed medication/medications for this problem, Stephanie will seek a referral for services from that medical or mental health professional before beginning services._____

7. In the case of #6, I agree to shared information from my M.D. or therapist/psychologist for the purpose of appropriate integration of services._____

8. I, the undersigned state that I am under the care of my own personal physician and therapist/ psychologist in all matters pertaining to and affecting my health._____

9. If I desire services not provided by Stephanie, which is my prerogative, I fully understand that I am free to seek them elsewhere. Stephanie may be called upon for reliable referrals._____

10. I understand that it is common to experience fatigue, and/or greater need to rest after treatment. It is sometimes common to experience a full range of emotions in the days after treatment. I agree to set aside the time to allow rest and assimilation of my experience._____

11. I fully understand that the services provided by Stephanie are not generally accepted or recommended by medical doctors or other conventional health professionals._____

Client Signature: _____

Date:_____

Name: _____

Address: _____

County _____

City:_____State: _____Zip: _____

Phone: (H) _____

(email):_____

Date of Birth: (mm/dd/yyyy) _____

Gender: M: _____F: _____