

# Waiver

## ***Expert Outcomes***

**Stephanie C. Shipper**

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**(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: \_\_\_\_\_