Visionary Health Medical Educational Clinic (VHMEC)
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INFORMED CONSENT – Life Coaching, Counseling Therapy, Generational Healing &/or Shamanic Services

TO THE CLIENT: You have the right, as a client, to be informed about therapy treatments of Counseling Therapy, Life Coaching, Shamanic Treatment and/or Generational Healing, so as make an informed decision whether or not to undergo the recommended treatment modalities after knowing the benefits and or risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to Therapy. I have agreed to the terms outlined:

If you refuse any future therapy this will not affect your receiving other care or future treatments in the Clinic.

- I **voluntarily accept** Angela Croft, MSW, RSW to provide services: Counseling Therapy, Life Coaching, Generational Healing . or Shamanic Treatments in my best interest, to better my health condition.
- I understand that anything I discuss in the above services with Angela Croft, MSW, RSW is strictly confidential.
- I also understand that I must give express written or verbal permission to Angela Croft, MSW, RSW to share any aspect of our work together that would identify me specifically and breach confidentiality.
- The only exceptions to confidentiality are in such cases where the issue of potential harm to myself and/or others is disclosed. I acknowledge that in such cases my own safety and/or the safety of others takes priority if the appropriate authorities need to be notified without my consent.
- By signing below I acknowledge that the limits of confidentiality have been explained in full to me, that any questions I have pertaining to the limits of confidentiality have been addressed, and that I am free at any time to request further clarification.
- I understand that there may be some health benefits and risks with Counseling Therapy, Life Coaching, Generational Healing . or Shamanic Treatments.
- I understand that I have the right and the opportunity to ask questions about my condition, discuss further therapy sessions, or any other therapy modalities at any given time.
- I may request additional information regarding the above services.
- I may cancel the appointment up to 24 hours prior to a scheduled session. A missed appointment will mean a missed session and it will not be refunded. (A business day is defined at Monday to Friday, excluding Holidays).
- I understand that all the plans/programs purchased are non-refundable and that the payment must be made before the first session of any of the plans purchased.
- I agree to allow my contact information be exchanged with the other medical professionals within Visionary Health or Team of Care under the guidelines/ jurisprudence of the College and/or institute in relation to the above services.
- Payment of services will be expected, based on the fee schedule.
- If any additional telephone, electronic, email or online services apply, I will be informed, and fees could be incurred.
- I further understand that any insurance reimbursement will be my responsibility until I authorize for direct billing to my insurance provider.
- Appointments will ordinarily be 60-90 minutes in duration, unless we agree to additional time and charges.
- In an emergency situation, I understand that I should not solely rely on reaching the practitioner and if there are any indications of an emergency, I am to go to my local hospital, contact the police department or dial 911.
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
- I give consent and authorize Visionary Health Medical Educational Clinic practitioner to contact me in the near future for continued treatment.
- I authorize Visionary Health Medical Educational Clinic to make contact to inform me of educational events, promotions, incentives, newsletters, and of any health benefits.
- I certify that I have read this form or have had it read to me, and that I understand its contents and meaning. I have sufficient information to give this informed consent.
- If the client is a minor under 18 years of age, I the undersigned, take full responsibility and acknowledge agreement to the above statements and act on their behalf.
- I am consenting to a virtual session or an in person clinic and agree to above.

Patient Name	Patient Signature	Date
_____	_____	_____