HOLISTIC OASIS STUDIO LTD.

CONSENT TO TREATMENT

Holistic Therapy is the treatment and prevention of diseases by natural means. Holistic Therapists assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

It is very important that you inform your therapist of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise the therapist.

There is slight health risk to treatment by Holistic Therapy such as an aggravation of pre-existing symptoms.

I realize that my identity will be protected at all times and if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the therapist to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures and any time

I will give 24 hours' notice, if I have to cancel an appointment. Exceptions made by family or other emergencies.

Date:_____

Patient Name: (please print)_____

Address_____ postal code_____

Telephone:_____ email:_____

Signature of Patient (or Guardian):_____

Name of Holistic Therapist: Sandi Melnychuk