

William Pitcher Hypnosis

Client Information and Agreement Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____ Age: _____

How did you find out about William? _____

The reason for your visit?

Have you ever been in therapy before?

Have you ever been hypnotized before?

Are you currently taking any medications? _____, and if Yes, please state for what reasons?

List your preferred communication method: _____

Do I have your permission to record your sessions? _____

What is Introspective Hypnosis?

It is a method that combines Ericksonian hypnosis techniques, enhanced by spirituality and the dynamics of forgiveness, in order to achieve behavioral changes, as well as to receive and resolve psychosomatic answers towards relief to the patient. This therapy can be used to treat various behaviors, such as phobias, fears, angst, sadness, anxiety, anorexia, bulimia, low self-esteem, insecurities, complexes, migraines, obesity, obsessive compulsive disorders, allergies and/or addictions.

I, _____, by my own free will, sign this waiver and accept all risks and I am perfectly aware that William Pitcher will be the person conducting the therapy sessions associated with hypnosis. **William Pitcher is NOT a licensed Physician, NOR is he a licensed Psychiatrist and he CANNOT diagnose NOR treat any type of physical or mental disorders.** I fully understand that these hypnosis sessions are solely for educational and/or emotional enrichment. I also understand that any suggestions made during any session are part of a personal motivational and educational goal and it's only of informational character. **William Pitcher DOES NOT pretend to be a licensed professional in Medicine or in any medical field and he is NOT a Mental Health specialist.**

With this document, I waive any claim to personal injury liability that may be the end result of any hypnosis therapy session. I also agree that William Pitcher assumes **NO** responsibility for the results of this therapy process, **NOR** does he guarantee its final outcome or effectiveness

I certify that I am a competent adult of legal age and I assume all risks and complete responsibility in the final outcome of this therapy. I am also voluntarily signing this consent form with my full legal name. This waiver and acceptance of risk is effective as of today and it can't be revoked, altered, modified, annulled or invalidated, without the prior written consent of William Pitcher.

Full Name: _____ **Date:** ____/____/20__

Patient's Signature _____

Full Name of Parent or Guardian _____

Signature of Parent or Guardian _____

(If the Patient is underage, the Parent's or legal Guardian's signature is required for legal consent of treatment).

CONSENT TO AUDIO AND/OR VIDEO RECORDINGS

By signing this document, I understand that this, as well as any future therapy sessions will be recorded by audio and/or video means. This is strictly for safety purposes and will also serve as a learning tool. At the end of each session, I understand I will receive a copy of any audio and/or video recordings made and the original recording will become the exclusive property of William Pitcher. These recordings will be held in strict confidentiality, except when the patient **DOES NOT** want to share the session in an anonymous way to promote the therapy methods developed by **Aurelio Mejía (Introspective Hypnosis)** William Pitcher will **NOT** be held responsible and is free of any liability due to damages caused through the unlawful use of any audio and/or video recordings made during of any therapy sessions, if posted or published on the Internet, by the Patient or third parties associated with or related to the Patient.

Full Name: _____ **Date** ____/____/20____

Patient's Signature: _____

CONSENT TO THE CONTENTS OF THIS DOCUMENT

By signing this document, I understand that I have carefully read and understand all the clauses of this document and I make the commitment to abide by all its clauses. My signature also means that I will have the opportunity to request clarification of any doubts that I may have about this subject and that I will be provided with answers in a satisfactory manner.

Full Name: _____ **Date** ____/____/20____

Patient's Signature: _____

AUTHORIZATION TO RECEIVE HYPNOSIS TREATMENT:

YES _____ **NO** _____ **PATIENT'S SIGNATURE:** _____