BEST Healing Montana LLC

Consent for a Remote B.E.S.T. Session from Caryn Rouse, Certified B.E.S.T. Practitioner

I _____ have received information and understand that Bio-Energetic Synchronization Technique, otherwise known as B.E.S.T., is a gentle, complementary energy based approach to health and healing that can assist my body in its natural ability to heal.

It has been explained to me that B.E.S.T. is a complementary therapy not intended to replace any currently prescribed medical treatments as ordered by my physicians nor any other medical care I have that I may be advised to seek by them.

I have been informed that Caryn Rouse will not diagnose any medical condition nor prescribe for any condition that I might have nor does she make any specific claims regarding results from the B.E.S.T. sessions that I receive.

I have been encouraged to consult a licensed medical practitioner for any physical or mental complaints I may have.

Some of the indications for a B.E.S.T. session include, but are not limited to:

- Reduction in pain, anxiety and stress
- Support of the body's natural healing process and sense of well-being
- Emotional-Mental-Spiritual support

I have been informed that all client information and records are treated in a confidential manner. My experiences during these sessions are confidential subject to the usual exceptions governed by State or federal laws and regulations.

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Caryn Rouse and BEST Healing Montana LLC from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

My questions have been answered to my satisfaction regarding Caryn Rouse's background, B.E.S.T., and what I might expect from this session.

I will speak up if at any time during the treatment I feel discomfort on any level.

I give my consent to receive B.E.S.T. from Caryn Rouse, Certified B.E.S.T. Practitioner.

Client/Parent/Guardian Name (printed) _____ Date_____

Client/Parent/Guardian Signature _____

Phone Number _____E-mail _____

Mailing Address _____

REMOTE SESSION
ENERGY MEDICINE CONSENT FORM

1. Remote services can involve the use of secure interactive videoconferencing devices and equipment that enable energy practitioners to deliver their services to clients when both are located at different sites. Please read this carefully, and let BEST Healing MT LLC know if you have any questions. When you sign this document, it will represent an agreement between you and BEST Healing MT LLC
2. I understand that the same standard of care applies to a remote session as applies to an in-person visit.
3. I understand that the laws that protect privacy and the confidentiality of personal information apply to remote sessions.
4. I understand that I will not be physically in the same room as my practitioner.
5. I understand that my basic personal information may be shared with other individuals for scheduling and billing purposes.
6. **Risks to confidentiality:** I understand that as remote sessions take place outside of the practitioner's office, there is potential for other people to overhear sessions if I am not in a private place during the session. The practitioner will take reasonable steps to ensure privacy. It is my responsibility to find a private place for the session where I will not be interrupted. I also understand that it is my responsibility to protect the privacy of our session on my cell phone or other device.
7. **Issues related to technology:** I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. For example, technology may stop working during a session, other people might be able to get access to a private conversation, or stored data could be accessed by unauthorized people or companies.
    - If it is determined that the video conferencing equipment and/or connection is not adequate, I understand that my practitioner or I may discontinue the remote session and make other arrangements to continue the visit.
8. **Right to Refuse:** I understand that I have the right to refuse to participate or decide to stop participating in a remote session, and that my refusal will be documented in my client record. I also understand that my refusal will not affect my right to future care or treatment.
    - I may revoke my consent at any time by contacting my energy practitioner at 406-880-6224.

9. **Records:** I understand that my practitioner will maintain a record of our session in the same way they maintain records of in-person sessions in accordance with their policies.
10. I understand that this document will become a part of my personal record.
11. By signing this form, I attest that I
    - (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; I have also read the form Preparing for Remote Healing.
    - (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to remote sessions shared with me; and
    - (3) I am located in the state of _____and will be in the state of _____during my remote session(s).

Client/Parent/Guardian Name (printed) _____

Client/Parent/Guardian Signature _____

Date_____