**Informed Consent**

I understand that Illinois issues licenses to health care professionals. This license authorizes them to analyze, assess, diagnose, evaluate, examine and investigate their patients to determine what's wrong with them. This license also authorizes them to advise, caution, counsel, guide, prescribe, recommend and suggest cures, drugs, interventions, remedies and treatments to address what's wrong with them. I also understand that if I need the services of a licensed professional, Chrystal Sawyers (Moyer) B.S LSH, CRTS will refer me to one.

I understand Chrystal Sawyers (Moyer) B.S LSH, CRTS is a Licensed Spiritual Healer qualified to help me surrender to the Divine and accept Devine healing on every level of my being.

I also understand Chrystal Sawyers (Moyer) is Certified Raindrop Technique Specialist CRTS who uses Raindrop Technique to help me relax, manage my stress, pain, enhance the quality of my life, help me detox my body from toxic pollutants I may unintentionally eat, drink inhale or absorb, and help me improve my performance for work, hobbies and other areas of my life.

I understand the Raindrop Technique is a non-secular art and science and is an application of essential oils. I understand the use of essential oils may help me improve the quality of my life. I also understand that human response to essential oils may vary considerably and are not predictable because of the unique chemistry, make up and intent of each individual.

I understand the natural therapies offered by Chrystal are not a substitute for adequate medical care. I intend to remain under care of my primary physician.

I understand all healing may cause some minor discomfort, and some adverse side effects may occur through no fault of my own or Chrystal. I have read and understand the “Eleven points to mention as a prelude to Raindrop” and or the “A Statistical Validation of Raindrop Technique”.

I understand my health is my responsibility. I will advise Chrystal of anything that might help us work together better to achieve the healing that I seek.

I understand my identity and any information about me, whether or not I share it with Chrystal or she discovers it on her own, will be held in the strictest confidence, except when released by me in writing or as required by law.

I acknowledge that I have read and understand this form. Chrystal has answered all my questions. I agree to allow Chrystal Moyer to help me learn to heal myself using the natural healing techniques and modalities herein listed.

This is signed and returned as documentation I have read and received the informed consent and scope of practice for Soul-Scents body work by Chrystal Sawyers (Moyer).

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_