Megan Brians, LMT OR #24955
Body & Being Healing | Pelvic & Abdominal Therapy
541-633-5977 | info@bodyandbeinghealing.com

# STATEMENT OF CONSENT FOR PELVIC & ABDOMINAL THERAPY

Name _______________________________________ Date ____________________

*Please initial your agreement or disagreement in the following spaces where indicated.*

## BILLING INFORMATION & RATES

Insurance is not accepted at this time. Payment is due at time of service. Fees are as described below unless otherwise agreed upon.

Initial 2-Hour Session: $220. 90-Minute Follow-Up Session: $180.

## CANCELLATION, NO-SHOW and LATE-SHOW POLICY

Please give at least 24-hour notice to cancel appointment. Without this notice, full payment for the missed appointment will be due prior to your next appointment.

If you are late for session, you will still owe the full fee for the session.

## PELVIC FLOOR EVALUATION/TREATMENT

I understand that a pelvic floor assessment includes an external and internal vaginal exam to assess pelvic musculature health. Sessions for treatment of findings may include internal vaginal massage, external abdominal/ uterine massage, external and internal rectal assessment or myofascial release, instruction in pelvic muscle and breathing exercises, Ortho-Bionomy (a positional release technique), Polarity Therapy (energy work), and postural attention.

I understand and agree to receive internal vaginal exam/treatment, and possibly rectal exam/treatment at the discretion of the therapist. I understand that I can change my mind, or request the therapist to stop at any time during the session. _________ *(initial)*

## ACCOMPANIMENT

I understand that I may bring a companion to be present during a session of internal vaginal pelvic bodywork if I so choose. I choose_____ do not choose_______ to have a companion present. *(initial one)*

## ACKNOWLEDGEMENT of NOTICE OF PRIVACY PRACTICES

I understand that Megan Brians does not use or disclose any personal or health information about any client without prior written agreement by client. I understand that this treatment is not a replacement for medical care, treatments, or diagnosis.

I certify that I have read, understand, and agree to this informed consent, and request and consent to receive these services from Megan Brians, LMT.

Patient signature ______________________________________________
Date__________________________