NATURAL HOPE CENTER
310 W. Wyomissing Blvd
West Lawn, PA 19609

Informed Consent Form

I, _____, hereby attest to the following:

I fully understand that Karen O'Connor ND, M.S. is a Natural Health CONSULTANT and EDUCATOR and offers consultations and therapy sessions solely because she desires to share her knowledge. I understand that she is NOT a licensed physician and cannot diagnose diseases, prescribe drugs or recommend treatments for specific disease conditions.

I understand that Karen O'Connor ND, M.S. neither claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent or mitigate any disease condition; but are provided solely for purpose of nourishing and strengthening the natural function of the various body organs and systems so that they may have a greater capacity to heal themselves.

I certify that Karen O'Connor ND, M.S. and her representatives have not suggested that I cease any medical care I may be currently undertaking. I understand that the decisions I make regarding my healthcare and the healthcare of those under my guardianship are my responsibility and certify that I will not hold Karen O'Connor ND, M.S. or her representatives responsible for the consequences of MY decisions. If I have not already done so, I agree to consult with a medical doctor for any serious or life – threatening disease condition, either for myself or for those under my guardianship.

I understand that Karen O'Connor ND, M.S. is also a state licensed and nationally certified massage and bodyworks therapist (License # MSG003524). I give full consent to her to use touch therapy for the basic purpose of relaxation and or pain/ muscular tension relief. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

If I experience any pain or discomfort during a consulting or therapy session, I will immediately communicate that to Karen O'Connor ND, M.S. so the session can be adjusted.

I have informed Karen O'Connor ND, M.S. of all my known physical conditions, medical conditions and medications, and I will keep her updated on any changes. I understand that there shall be no liability placed on her due to my failure to relay any pertinent information.

In signing this declaration, I acknowledge that I understand the above consent form.

Client Signature _____ Date _____