**Statement of Consent for Integrative Pelvic Bodywork**

**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

1. **BILLING INFORMATION & RATES**

To maintain lower rates, insurance is not billed. I understand that rates are offered on a sliding scale dependent on my ability to pay. Insurance is not accepted at this time. Payment is due at time of service.

*General Rates: (****If needed, ask about sliding scale options.*** )

**Initial intake visit:** $195 (90-120 min). **Subsequent visits**: $ 145 (90 min).

1. **CANCELLATION and NO 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.

1. **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 observation of the perineal area, pain assessment externally, internal vaginal massage, external abdominal/uterine massage, external and internal rectal assessment or myofascial release, instruction in pelvic muscle and breathing exercises, cranial sacral therapy, 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)***

1. **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)***

1. **ACKNOWLEDGEMENT of NOTICE OF PRIVACY PRACTICES**

I understand that Leslie Stager 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 understand that no guarantees have been or can be provided regarding the success of therapy. I have informed Leslie of any condition that would limit my ability to have an evaluation or be treated.

I certify that I have read, understand, and agree to page 1 and 2 of this informed consent, and request and consent to receive these services from Leslie Stager, RN, LMT.

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINTED NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**