Informed Consent for Esogetic Color Puncture Treatment

This is to inform you of your rights as my client and for you to sign your consent to receive treatment. Your treatment is confidential. Your Esogetic Color Puncture Treatment rights are as follows. My privacy practices are in a separate document. You have the right to withdraw your consent at any time in writing.

Disclaimer: Esogetic Color Puncture Treatment is not intended to replace medical treatment nor is it a medical diagnosis. Esogetic Color Puncture is to support the treatment provided with Creating Balance LLC. Appropriate medical professionals should be consulted for proper medical advise before engaging in any new treatment and to address medical questions.

I have read and understand the terms of this consent. I have been given the opportunity to have my questions answered to my satisfaction. I have honestly disclosed to the best of my ability all of my conditions and concerns that could be affected by treatment. I will notify Creating Balance of any changes as they occur.

My signature below is my consent to Esogetic Color Puncture Treatment to support my mental health treatment with full knowledge of my rights and understanding that this is not to replace medical treatment or advise. I also have received a copy of Creating Balance LLC's Notice of privacy practices.

_____
Print Clients Name

_____ ____/___/____
Client Signature Date