Spirit of Healing
Client Notification Form

Please read the following prior to contracting for services:

Name of Practitioner: Jessica Hazelbaker-Buell, MA, LMT
CranioSacral Therapy Practitioner
Intuitive Healing Practitioner
Licensed Massage Therapist
Direct Entry Midwife

Business Address: 5115 Olentangy River Road
Columbus, OH 43235

Telephone number: (614) 326-3504

The following is a brief description of my education, training, experience, and credentials:

I have a Bachelor's Degree in Creative Writing with a minor in Sociology from Otterbein College. I have a Master's Degree in European and Comparative Literary Studies from the University of Kent, Canterbury, England. I began my CLC training with Alison Hazelbaker, PhD, IBCLC, FILCA, CST-T, RCST, PPNE in January 2009. In 2011, I graduated from Sacred Mountain Midwifery School as a Direct Entry Midwife and went through a homebirth midwifery apprenticeship under Certified Professional Midwives until 2013. I am pursuing my certification to become a Certified Craniosacral Therapist (CST) through Upledger Institute. I began my Craniosacral training with Upledger Institute in April 2019. I am a Licensed Massage Therapist, having graduated from Columbus State Community College with a Certificate in Massage Therapy and having passed the licensing exam in August 2021. I am also an Intuitive Healing Practitioner and have been practicing since 2019.

Note: The State of Ohio has not adopted any educational or training standards for persons who provide information or perform craniosacral therapy or Intuitive Healing to clients. This statement of credentials is for informational purposes only. Under Ohio law, massage therapists, craniosacral therapists, and Intuitive Healing practitioners are not allowed to provide a diagnosis or to recommend discontinuance of medically prescribed treatment. If you desire a diagnosis from a licensed healthcare practitioner, you may seek those services at any time.

I have read and understand the Therapy and Credentials section: _______ (Please initial here)

FINANCIAL POLICY SECTION

Fees

My fees are $90 per hour for my services. Sales tax will be collected on massage therapy services unless you provide a prescription from your chiropractor, primary care provider, or other licensed health provider that we may keep on-file for you. I bill by the quarter hour after the first hour of service. Payment is due in full at the time of service unless an alternative payment arrangement has been made. I accept cash, checks, Visa, MasterCard, American Express and Discover. I also accept Health Savings

Account cards for payment. If fees are not paid in full, I reserve the right to charge interest in the amount of 18% annually for the fees not paid. By providing your credit card number below, you are giving permission for your card to be charged for distance appointments and/or missed appointments. Further, this allows for contactless payments.

Credit card number: ____
Expiration: ________________ CVV: ______________ Billing zip code: ________________

I, ______________________________, authorize Spirit of Healing, LLC, to charge the credit card number above for my appointments.

Insurance

I do not directly bill insurance companies nor do I accept assignments from insurance companies. I am happy to provide you with a CPT coded bill for you to submit for reimbursement. You will also need to obtain a Diagnosis code from your medical provider, such as a physician or chiropractor, for your claim to be processed by your insurance company. At this time, insurance companies may reimburse for Craniosacral Therapy, but it is unknown what the rate of reimbursement is for these services by most medical insurance companies. I DO NOT GUARANTEE SUCH REIMBURSEMENT, but encourage all clients to submit for reimbursement so insurance companies may see the value of this therapy. I am happy to answer any questions that you may have about this.

Usual and Customary Fees

I am committed to providing exemplary service for which I charge fees that are usual and customary for this area. You are responsible for payment regardless of any person or party's arbitrary determination of what constitutes usual and customary fees.

Cancellation and Tardiness Policy

Appointment charges are not prorated should you arrive late for a session; THE FULL HOUR CHARGES WILL APPLY. I also am unable to extend your appointment time should you arrive late for a session, as my other clients and their appointments are also important to me.

I REQUIRE 24 HOURS NOTICE FOR ANY APPOINTMENT RESCHEDULING OR CANCELLATION. If you fail to show up for an appointment or make changes with less than 24 hours notice, you will be charged for the appointment. Any individual who fails to show or cancels appointments less than 24 hours in advance three times will be referred to another practitioner. We have a wait list of clients who are given priority access to cancelled appointments. Our staff manages rescheduling. Patients may not exchange or switch appointments with other patients independent of our office.

Returned Checks

Any check that is returned for any reason will be assessed a fee that is equal to but not more than the fee assessed by my bank. A replacement check will not be acceptable restitution. An alternative form of payment of cash, cashier's check, Visa, MasterCard, American Express or Discover will be required.

I have read and understand the Financial Policy section: ________ (Please initial here)

RIGHTS SECTION

Practitioner rights:

1. I have the right to accurate health history information from you. Optimal treatment follows on the heels of thorough and open communication about health concerns.
2. I have the right to hear about any concerns you may have with the treatment process and our therapeutic relationship. I cannot appropriately address something I do not know is a concern for you.
3. I have the right to courteous treatment free of verbal, physical or sexual abuse.
4. I have a right to terminate any client if that client:
    a. Would better be served by a different provider or modality.
    b. Has been or is verbally abusive to me or any other member of my staff, or sexually harasses me or any member of my staff.
    c. Continuously cancels appointments, is a no show for appointments, or fails to pay for appointments in a timely fashion or as previously agreed.
    d. Gossips about and/or commits libel or slander against me in the community.

Your rights:

1. You have the right to file a complaint against me with my professional associations.
2. You have the right to be notified in writing of any changes in my fee schedule.
3. You have the right to receive complete and current information concerning the assessment and recommendations I make, including the expected duration of these services.
4. You may expect courteous treatment, free of verbal, physical, or sexual abuse.
5. Your records and transactions are confidential, unless you authorize their release in writing or as otherwise provided by the law.
6. You have the right to choose among available service providers and to change providers after my services have begun, within the limitations of any applicable health insurance medical assistance or other related programs.
7. You have the right to a coordinated transfer if you opt to change service providers.
8. You may refuse the services at any time except as otherwise provided by law.
9. You may assert your rights without any fear of retaliation.

I have read and understand the Rights section: ______ (Please initial here)

PHILOSOPHY SECTION

The following is a description of my philosophy, and what you can expect from me:

Health lies within us all, waiting to be mobilized. My role as a therapist is to support and nurture the body's inherent health utilizing the skills I have learned in my training. These skills can release soft tissue restrictions, optimize the flow of cerebrospinal fluid, blood and lymph, optimize nerve function, increase body awareness, increase relaxation, support the release of emotions generated by ill health, and decrease the symptoms of stress. You can expect me to use my skills and training to the best of my ability to support your goals of health and well being.

I have read and understood the Philosophy section: _____ (Please initial here)

PRIVACY NOTICE

All uses, disclosures of, or requests for protected health information (PHI) will be limited to the minimum amount necessary to accomplish the stated purpose. Professional judgment will determine the amount of information to be released. The minimum necessary standard is not intended to impede the provision of quality health care.

Disclosures of PHI between providers for treatment, payment and health care operations, or pursuant to an authorization without complying with this requirement are exempt from the minimum necessary rule. Occasionally, providers share details about certain cases for the purpose of educating a student, apprentice, intern, or colleague, or getting input on an aspect of a case for which they require assistance. This sharing of case details preserves anonymity, while demonstrating the utmost respect for the client and their family. *AT NO TIME ARE ANY DETAILS OF A CLIENT-THERAPIST RELATIONSHIP SHARED FOR THE PURPOSE OF BELITTLING OR GOSSIPING ABOUT THAT CLIENT OR THEIR FAMILY. AT NO TIME SHOULD YOU SHARE ANY DETAILS OF THE CLIENT-THERAPIST RELATIONSHIP FOR THE PURPOSES OF BELITTLING OR GOSSIPING ABOUT YOUR THERAPIST. IF YOU HAVE CONCERNS ABOUT YOUR THERAPIST OR YOUR TREATMENT PLEASE DISCUSS WITH YOUR THERAPIST DIRECTLY OR OUR OFFICE MANAGER SO YOUR CONCERNS MAY BE ADDRESSED.* Please ask me about this if you have questions or concerns.

I have read completely the Client Notification Form and understand my rights, the qualifications of the person providing services, and what I should expect from the provider. I also understand and agree to the financial and cancellation policy. I have provided my credit card details to be kept on file and used ONLY if I cancel or miss an appointment without giving at least 24-hours notice.

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Signature of Client   Date