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# POWER OF THE MIND® HEALING CENTER

Counseling, Hypnotherapy, Scenar® Therapy, Chakras  
Tuning Fork Cymatic Therapy, Essential Oils and Reiki Energy Healing

For a Healthy Body, Mind, and Soul

*In Association with Healing Light Ministries*

## **Dr. Sharon A. Jackson, Ph.D.**

Metaphysician, Counselor, Certified Clinical Hypnotherapist

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**Please fill out the following information completely as possible. All information will be treated as confidential. PLEASE PROVIDE DRIVERS LICENSE NUMBER AND STATE IF YOU WILL EVER SUBMIT PAYMENT IN THE FORM OF A CHECK**

Name (First): \_\_\_\_\_ (Last) \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: \_\_\_\_\_

Drivers License No. \_\_\_\_\_ Issuing State \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_

Cell phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**EMERGENCY CONTACT**

Name: \_\_\_\_\_

Phone: (        ) \_\_\_\_\_ Cell:(        ) \_\_\_\_\_

How did you hear about Power of the Mind Healing Center?

\_\_\_\_\_

Have you ever been hypnotized before? \_\_\_\_\_ Reason \_\_\_\_\_

\_\_\_\_\_

When (approximate date) \_\_\_\_\_

What do you wish to accomplish in your private sessions? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently taking any medications? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please list medications

\_\_\_\_\_

The signee herewith will not hold Power of the Mind or any of it's agents responsible in any way, nor shall any claims be valid, in reference, to such methods, instructions, and programs in teaching relaxation, self-improvement, resolutions, and/or habit control. I hereby release and hold harmless Power of the Mind Healing Center and any of it's agents or representatives from any liabilities or claims arising from any sales or services rendered. I further agree that I will not prosecute or aid in any way the prosecution of any demand, claim, or suit against Power of the Mind Healing Center and any officer, agency, or any employee acting officially or otherwise, for any loss, damage, or injury to my person or property that may occur from their negligence as a result of me taking part in services or products sold or rendered. I understand that any appointments made and not cancelled within 24 hours will be billed at the current regular rate, any discounts will be void. I further agree and I will be responsible for making payment due within 10 business days. All balances must be paid within 30 days to avoid additional billing fees, reversal of courtesy discounts, and/or collection. I understand that any book(s) not returned in the condition loaned within 30 days, will be billed for replacement and I shall be responsible for such charges. I understand this agreement and understand it's concepts. I am aware that I am releasing certain rights that I otherwise may have, and I enter into this agreement on behalf of myself, my minor child(ren), and/or wards, of my own free will. Thank you for your cooperation and understanding with this matter.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_