MR. DERVISH
Rumi Academy

INSPIRE MINDS
BY SHAFIEI

Sufi Regression

Disclaimer form

Liability

I ..... hereby release Sufi Regression from any liability or claims that could be made against her and him concerning my mental and/or physical well-being during or following our work together, which has been outlined and agreed upon by signing this form

Scope of Practice

I understand practitioners are not licensed physicians, psychologists, or medical practitioners of any kind and that hypnotherapy & voice activation should not be considered a replacement for the advice of and/or treatment prescribed by a psychiatrist, psychologist, psychotherapist, or doctor.

Participation

I have received information about the proposed treatment and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment.

I acknowledge that the treatment is not completely risk-free and that practitioners will take reasonable steps to limit any complications of the treatment. I shall hold practitioners and their employees harmless of any unforeseen complications that may result from the treatment.
I shall hold practitioners and employees harmless of any hidden history and lifestyle history that may affect the given treatment

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Info@inspiremindsme.com

Phone
+971568420009
WhatsApp
+971508308190

Address
Dubai , Sheikh Zayed Road , AL Joud Center

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Guarantee

Although hypnotherapy has a very high success rate, practitioners cannot and do not guarantee results. My success depends upon many factors that the Coach has no control over, including my willingness and desire to effect change within myself.

Deepening Process

I hereby grant permission to the Coach to respectfully lift my arm, touch my shoulder, or rock my head during any hypnotherapy session(s) (when working in person) in order to help facilitate the deepening process.

Confidentiality

I understand that authorize practitioners to use my personal information within the premises of the IM facility and between employees of practitioners.
I understand that uses and disclosures already made based on my original permission cannot be taken back.
I understand that practitioners customize each treatment to target their Client's specific issues after studying details about the Client's health history and lifestyle. I understand that my treatment is specifically designed for me and I am unauthorized to share details of the treatment with any other persons or recommend the same treatment to them.

Patient or Guardian (If below 21 years old)

Full name: .....

Signed: .....

Dated: .....

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Info@inspiremindsme.com

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