



Consent Form

I understand that I am contracting with Kathy Doner, M.D. for hypnosis sessions only.

This does not constitute a physician-patient relationship, nor does it involve the practice of medicine. I will contact my personal health care provider for any medical needs.

I understand that a medical referral from my physician is required if hypnosis is for medical diagnoses or affects my medical condition. I understand that it is my responsibility to contact my physician for guidelines about changing diabetic, hypertensive or other medication.

I am willing for Dr. Doner to release information to my physician(s) and other health care providers only about my choice of hypnosis and my progress. (All other information is kept absolutely confidential.)

I understand that when canceling or rescheduling an appointment **24 hour advance notice is required** or a **\$35.00** fee will be charged. Any subsequent no shows or cancellation or rescheduling with less than 24 hour notice results in my being charged the full hourly fee.

Stopping Smoking Sessions: I understand that this program is two sessions with listening to a tape or CD between sessions for maximum benefit. I understand that the total fee is payable the first session, and is non-refundable, even if I choose not to attend the second session.

Name _____ Date _____

Address _____ City _____ Zip code _____

Home PH _____ Work PH _____ Cell PH _____

E-mail _____

Kathy Doner, MD

7766 Bay St., Suite 11 :: Bay Street Center :: Sebastian, FL 32958
Phone: 772-581-0221 :: KathyDonerMD.com

Physician(s) and other health professionals (ex. chiropractic, acupuncture, massage): name, specialty and city

How did you hear about Dr. Doner? _____

Your Signature _____

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