

**SERVICE AGREEMENT**

**Your Rights as a Client:**

The practice of licensed and unlicensed persons in the field of psychotherapy is regulated by the state of California. You are entitled to receive information about methods of therapy, techniques used, the duration of therapy, if known, and the fee structure. You are also to be informed of the therapist's degrees, credentials, or licenses.

**Confidentiality:**

I will not release your information to anyone without a written authorization from you, except as provided for by law. You have a right to be allowed access to my written record about you.

**Fees and Payments:**

Single EFT Session:	\$ 275
Single Hypnosis Session:	\$ 475
Four Session Series:	\$1092
Ten Session Series:	\$2184

Appointments are scheduled for one hour and include a customized CD recording for your personal use. Hypnotherapy is not guaranteed. There are no refunds. Sessions must be completed within one year of payment. Fees are due and payable at the time of service. I accept cash, checks, MasterCard, Visa and Discover.

**Cancellations:**

It is my policy to charge for each session you fail to appear, or for cancellations received less than 24-hours.

**Termination of Therapy:**

It is your right to terminate therapy at any time. There are no refunds. Termination is a very important process; therefore, I encourage you to discuss this decision with me. I will discuss your progress with you at any time. If I see you approaching readiness to leave therapy, I will address this with you.

**Disclaimer:**

The services you receive are not a substitute for normal medical care. Hypnosis is not a cure for all of life's problems. The most accurate way to define hypnosis is to call it guided meditation. It can be used to manage pain, quit smoking, release weight, reduce stress or anxiety, overcome phobias and fears, manage sleep disorders, and much more.

By my signature below, I, as the client, am signifying that I am willing to accept the hypnotherapy offered me for the purpose of self-improvement. I understand the services I receive are not a substitute for normal medical care and am hereby advised to discuss medical services with my physician. I agree to accept full responsibility for my choices and experiences, and release Rebekka Putnam from all liability for such. I agree to have my session audio recorded when applicable, and understand I will receive a copy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Rebekka Putnam, CHT

\_\_\_\_\_  
Certification # 303-220

\_\_\_\_\_  
Date