

Mercier Therapy Informed Consent and Release Form

I understand that Mercier Therapy is a soft tissue visceral manipulation therapy technique used to help and restore the health and general well being of the female pelvis.

I understand the goal of Mercier Therapy pelvic treatment is to decrease adhesions in and around organs, ligaments, muscles, joints and support structures of the pelvis, abdomen, hips and low back.

I understand that if I experience any pain or discomfort during a session, I will immediately inform the practitioner so that the pressure and/or application may be adjusted to my level of comfort.

I understand that Mercier Therapy should not be construed as a substitute for a medical examination, diagnosis or prescription. I should see a Gynecologist, Reproductive Endocrinologist or other qualified medical specialist for any physical ailment or suspect condition I might have.

I understand that Mercier Therapy is not intended to take the place of medical/surgical intervention and my practitioner, Jennifer Mercier, ND, PhD shall not bear any responsibility for any ill effects should I choose to NOT adhere to my primary doctor's advice.

I understand that the practitioner is not qualified to diagnose, prescribe or treat any emotional or mental distress and nothing said in the course of the session (s) given should be construed as such.

Because Mercier Therapy is contraindicated (should not be done) under certain medical conditions (IUD, Essure, Endometriosis during menses, any present cancer cells) I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there will be no liability on the practitioner, Jennifer Mercier, ND, PhD should I forget.

Supplements recommended or suggested to me are taken/ingested by my choice/decision. I will not hold the practitioner, Jennifer Mercier, ND, PhD responsible nor liable should I have an adverse or allergic reaction.

I understand that most of the supplements should be discontinued at the first determination of pregnancy.

I understand the remainder of treatment sessions will resume post partum should I conceive during the program.

I will honor all office policies including but not limited to payment, cancellation notice, tardiness and conduct. I understand refunds are not given for any reason.

I understand compliance is necessary for successful treatment progress and results. I understand there is no guarantee of pelvic cure or pregnancy. I have read, fully understand, and agree to the above terms and conditions.

PrintName: _____

Signature: _____ **Date:** _____

Practitioner Name: _____