



Janna M. Larsen, CHT • 227 North 850 West, Orem, UT 84057 • (801) 680-3611 • jannalarsen@gmail.com

## APPLICATION FOR SERVICES

CLIENT - PERSONAL INFORMATION				
First Name	M.I.	Last Name	Today's Date	
Street Address				
City	State	Zip	Birth date	
Home phone (ok to leave msg? Y - N)	Cell phone (ok to leave msg? Y - N )	Age	E-mail	Sex: M F

Spouse/Parent Information if under 18				
First name	M.I.	Last name	Marriage date	
Street Address				
City	State	Zip	Home phone	
Work phone	Birth date	Relationship to you		

PROVIDE INFORMATION HERE YOU WISH TO VOLUNTEER TO AID US IN UNDERSTANDING YOU AND WHAT YOU HOPE TO ACCOMPLISH BY UTILIZING BEHAVIORAL MODIFICATION CLINICAL HYPNOTHERAPY AND MIND MANAGEMENT

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HOW DID YOU LEARN OF OUR SERVICES? NEWSPAPER \_\_\_\_\_ INTERNET WEBSITE \_\_\_\_\_ RADIO \_\_\_\_\_

REFERRAL FROM: CHURCH LEADER \_\_\_\_\_ DOCTOR \_\_\_\_\_ PSYCHOLOGIST \_\_\_\_\_ OTHER \_\_\_\_\_

INCENTIVES GIVEN TO REFERRING INDIVIDUALS. PERSON WHO REFERRED YOU \_\_\_\_\_

Signature	Signature of Parent or Guardian
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## JANNA M. LARSEN CHT - STATEMENTS OF DISCLOSURE AND UNDERSTANDING

Janna is a Certified Clinical Hypnotherapist registered with the American Council of Hypnotist Examiners (CHT 121-032). She completed training in Clinical Hypnotherapy and Positive Mind Management under W. Dennis Parker of the "Certified Hypnotherapy Training School".

She assists people to discover, recognize, and overcome self-limiting beliefs and self-defeating behaviors, eliminate inappropriate habits, and conquer maladaptive behaviors, and teaches clients personal problem solving skills through self-hypnosis trance access to the subconscious, creating conscious and subconscious predominant thought alignment and overcoming "Double Mindedness", which is keeping them from personal achievement. She believes that we all have unlimited potential to grow and develop our abilities and learning skills. She teaches people how to be free of fear, anger, guilt, and other negative emotions.

### **Confidentiality:**

Confidentiality will be strictly maintained except for the following circumstances:

(1) with your permission and a signed release of information to a particular person or agency. (2) By law, any report of physical, sexual abuse, or neglect of a minor, or abuse of spouse or an elderly person. (3) If I have reason to assume that you may harm yourself or another person. I use a cell phone so that I am accessible, which cannot be considered 100% secure. Initials

### **Payment for Services:**

Payments are to be made immediately following each session. Insurance carriers in the State of Utah do not as a practice cover these therapy sessions. I understand I am personally responsible for payments.

Initials

To get the most from each session, it is recommended you arrive 10 minutes early to complete preparation forms. Fees for the various sessions are available via inquiry at jannalarsen@gmail.com.

### **Cancellation of appointments:**

On occasion, a situation may arise which prevents you from keeping your scheduled appointment. Please notify me *24 hours* in advance of your appointment if you cannot keep it. Except in emergency situations, you will be expected to pay for any sessions that you miss without this advanced notice. If you cannot provide 24 hours advance notice, you have purchased the time as it was reserved for you, and will be billed accordingly.

Initials

- > I have received a copy of the statement of disclosure. I have read and understand the information.
- > I have been informed of the terms of confidentiality and agree to them as stated above.
- > I agree to pay for each session at time of service.
- > I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the hypnotherapy process at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification. Initials

We reserve the right to refuse hypnosis and hypnotherapy services and training to anyone. **We do not work with drug addictions, alcoholism, and diagnosed mental illness disorders.** Initials \_\_\_\_\_

I understand that if I am currently working with a medical or mental health care provider and have been diagnosed with a medical or mental health disorder, and I am taking prescription drugs for the disorder, and should I want to work on a behavioral modification issue with hypnotherapy, **I am responsible to inform my mental health care provider, and the doctor who may be prescribing any medications, and explain to them what I am considering doing with hypnotherapy for behavioral modification.** Initials \_\_\_\_\_

**We prefer that you bring us a prescription from your mental health care provider and the doctor who is prescribing your medicine prescriptions to have us work with you for behavioral modifications with hypnotherapy, so they are always informed of what you are doing. If they have any questions, please direct them to the website: [www.certifiedhypnotherapytraining.com](http://www.certifiedhypnotherapytraining.com) or have them contact Janna to answer questions or address concerns: PHONE: (801) 680-3611. These procedures are standard operating practice and are accomplished on a routine basis.** Initials \_\_\_\_\_

I have \_\_\_\_\_ or have not \_\_\_\_\_ attended an individual or group hypnotherapy session and or workshop training with Janna M. Larsen before. (Please put an x in the appropriate box.) Initials \_\_\_\_\_

I have registered to attend hypnosis, self-hypnosis, and hypnotherapy individual or group sessions of hypnotherapy and training with Janna M. Larsen. **I STATE AND UNDERSTAND THAT I HAVE BEEN DULY ADVISED AND INFORMED THAT HYPNOTHERAPY SESSIONS DONE IN INDIVIDUALY AND/OR GROUP SETTINGS, COULD BE A VERY INTENSE PERSONAL EXPERIENCE, AND I UNDERSTAND AND WARRANT THAT I AM PHYSICALLY, MENTALLY, AND EMOTIONALLY CAPABLE TO ATTEND THE HYPNOTHERAPY SESSIONS AND/OR SELF-HYPNOSIS TRAINING WORKSHOPS.** Initials \_\_\_\_\_

We may deem that the group hypnotherapy seminars/workshops are not the appropriate setting for you, and ask you to do individual hypnotherapy sessions. Or should we feel that what you as the client needs and requires in services is beyond our scope of service and practice, refer you to seek other assistance. Initials \_\_\_\_\_

We reserve the right to have anyone leave the group hypnotherapy settings, at our discretion for any reason. Especially should you be disruptive, non-supportive of others in the group, or in any way viewed as being detrimental to the success of the group, or the creation of a positive, environment, attitude, and healthy healing atmosphere.  
Initials \_\_\_\_\_

If for any reason you are asked to leave the group and you have prepaid the sessions, we will refund the portion of the first group of session participation that is not yet accomplished. THERE IS NO REFUND FOR SECOND GROUP PARTICIPATION, AS IT IS BEING OFFERED AS ADDITIONAL ASSISTANCE - FREE. Initials \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Janna M. Larsen CHT**

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

(I/We) \_\_\_\_\_

Do hereby give permission to Janna M. Larsen CHT to mutually exchange all information regarding (my/our) social, emotional, educational, religious, psychological and medical histories, including assessment, backgrounds, opinions, and any other relevant data necessary to assist Janna M. Larsen CHT in providing continuity of services to (me/us):

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

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

Phone: \_\_\_\_\_

(I/We) agree to indemnify and hold harmless all persons and groups named above from any and all liability for claims, actions, damages or suits arising from or relating to the release or exchange of information made pursuant to this Authorization for Release of Confidential Information.

Except as authorized herein, confidential information will not be disclosed without (my/our) consent, except where the law may compel disclosure (1) to inform appropriate persons if there is reason to believe I am in danger of doing serious harm to myself or someone else, or (2) if there is reason to believe that reportable child/spousal or other abuse has occurred.

(I/We) have read the foregoing, understand its content, and agree to these conditions. (I/We) understand that this consent may be revoked at any time, except to the extent that action has been taken in reliance on it, or until (I/We) cancel it by written notice to the agency. In any event this consent expires automatically on-hundred-twenty days after date of signature.

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

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

Witness \_\_\_\_\_ Date \_\_\_\_\_

If under 18 years of age, signature of parent or legal guardian is required.

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

**FOR CLIENTS CONTINUING SERVICES**

A New Authorization for Release of Confidential Information is required is required for clients continuing services beyond 120 days. (I/WE) hereby authorize the above-named individuals to mutually exchange information as needed as a condition of (I/My/Our) continuity of services. (I/We) agree to the conditions stated in (my/our) original authorization above, and understand that this consent may be revoked at any time, except to the extent that action has already been taken in reliance on it, or until (I/We) cancel it by written notice. In any event this consent expires automatically ninety days after date of signature.

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

Witness \_\_\_\_\_ Date \_\_\_\_\_

If under 18 years of age, signature of parent or legal guardian

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



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## Pay Agreement for Services: Stake President, Bishop, Parent or Guardian

Rendered by: Janna M. Larsen CHT

I, \_\_\_\_\_, agree to reimburse Janna M. Larsen CHT  
on behalf of \_\_\_\_\_ (Client) for services  
provided by Janna M. Larsen CHT in the amount of:

\$ \_\_\_\_\_, or until \_\_\_\_\_ date.

**I agree to pay the entire balance on a monthly basis.**

Signed: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address to send billings: \_\_\_\_\_

**If you wish to receive confidential reports of client progress, please have the client fill out, sign, and return, the attached: AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**



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## Credit Card Payment Information

First and Last Name: \_\_\_\_\_

Name on Card: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

We will use this number to contact you should there be a problem.

Email Confirmation: \_\_\_\_\_

We can accept any of the four major credit cards; MasterCard, VISA, AMEX and Discover.

Circle Credit Card Type:      Master Card -   VISA -   AMEX - Discover

Amount: \_\_\_\_\_

Card Number: \_\_\_\_\_

Exp. Date: \_\_\_\_\_

CCV: \_\_\_\_\_

Would you like us to keep this card number on account? Yes \_\_\_\_\_ No \_\_\_\_\_

Authorized by: \_\_\_\_\_

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

Please contact Janna direct at (801) 680-3611, or Email us at: jannalarsen@gmail.com should you need any assistance.