

CONSENT FOR SCENAR TREATMENT

Name _____

Date of Birth _____

ID# _____

I understand that as a client of SCENAR Care, LLC the treatment I will receive will be determined following initial and ongoing assessments and through discussions with me. The goal of the assessment process is to determine the best course of SCENAR treatment for me. Typically, treatment is provided over the course of weeks or months with specified breaks in treatment that are an important component of the overall treatment process.

I understand that all information shared with the therapists at SCENAR Care, LLC is confidential and no information will be released without my consent, except as required by law. During the course of treatment at SCENAR Care, LLC, it may be necessary for my therapist to communicate with providers at my primary or referring clinic. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- A. When there is risk of imminent danger to myself or to another person, the nurse/therapist is ethically bound to take necessary steps to prevent such danger.
- B. When there is suspicion that a child or vulnerable adult is being sexually or physically abused, or financially exploited or is at risk of such abuse or exploitation, the nurse/therapist is legally required to take steps to protect the child or vulnerable adult, and to inform the proper authorities.
- C. When a valid court order is issued for medical records, the therapist and the agency are bound by law to comply with such requests.

I understand that while SCENAR therapy, may provide significant benefits, it may also pose risks. SCENAR therapy may elicit uncomfortable thoughts, feelings, sensations, or symptoms. SCENAR therapy may have unwanted side effects including loss of pregnancy or unplanned pregnancy, fetal complications, reversal of tubal ligation, healing crisis, unknown or undetermined outcomes or death. I understand that persons with pacemakers or those with organ transplants should NOT use SCENAR. I understand that other conditions with limits or contraindications for SCENAR include heart fibrillation, intoxication, personal intolerance, pregnancy, and severe mental disorder.

I agree that I have been given no guarantee of any specific outcome from treatment provided to me by SCENAR Care, LLC. If I have any questions regarding this consent form or about the services offered at SCENAR Care, LLC, I may discuss them with my nurse/therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by SCENAR Care, LLC. I understand that I may stop treatment at any time.

Client or Guardian Signature _____ Date _____

SCENAR Care, LLC
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