



## REDWOOD EMPIRE ROLFING®

3452 B MENDOCINO AVENUE  
SANTA ROSA, CA 95403

PHONE: 707-542-2001  
EMAIL: CAROLE34@COMCAST.NET

### Patient Disclosure

To: \_\_\_\_\_  
(name of client)

Welcome to my practice. As you know, I am a practitioner of Rolwing® structural and movement integration. I am not a licensed physician, nor are Rolwing services licensed by the state.

I have been practicing manual therapy since 1992 and Rolwing since 1996. My training and education is described below:

Rolf Movement Certification	2002
Advanced Rolwing Certification	2000
Rolwing Certification	1996
Massage Certification	1992
B.A. from Sonoma State University	1990

I am a member of the Rolf Institute and licensed as a massage practitioner in Washington state. I am Nationally Certified in Therapeutic Massage and Bodywork, a member of the International Association of Structural Integrators, and a Professional member of the American Massage Therapy Association.

In addition to the above listed certifications I have also completed over 400 hours of continuing education in Rolwing manipulation, Rolwing movement, and other forms of manual therapy and movement education. I have completed 277 hours of training in Bodydynamic Somatic Developmental Psychology and their approach to working with Post-Traumatic Stress Disorder. I have also completed one year of training (350 hours) in Biodynamic Craniosacral Therapy.

In order to use my services, California state law requires that you acknowledge receipt of the information provided in this form and that you sign it. You will receive a copy. I will keep the original in my records for at least three years.

My method of treatment, Rolwing, is alternative or complementary to healing arts that are licensed by the State of California. Under Sections 2053.5 and 2053.6 of California's Business and Professions Code, I can offer you these services, subject to requirements and restrictions that are described fully on the attached page.

If you ever have any concerns about the nature of your treatment, please feel free to discuss them with me. I recommend that you inform your medical doctor that you are receiving Rolwing treatment.

### **Right of Refusal**

I reserve the right to refuse service to anyone. This includes but is not limited to anyone who requests treatment or services that are outside my scope of practice. I will exercise this right if anyone arrives for treatment under the influence of alcohol or recreational drugs; I reserve the right to charge for the session time, whether or not services were rendered, if I so choose.

### **Acknowledgement and Consent to Receive Services**

I fully understand the purpose of Rolfing is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. This is accomplished through direct soft tissue manipulation and movement education so that greater economy and freedom of body-movement are achieved.

The Rolfing practitioner does not prescribe or diagnose illness, disease, or any other physical or mental disorder of the person. Nothing said or done by a Rolfer should be misconstrued to be such. Medical diagnosis or treatment should be sought when such attention is needed.

I understand it is necessary for the Rolfing practitioner to touch my body in order to assist me in establishing balance and alignment.

I give Carole LaRochelle my permission and consent to do all those things necessary to help me establish balance and alignment, including, but not limited to touching my body. I give the Rolfer full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein.

I have read and understand the above disclosure about the Rolfing treatment offered by Carole LaRochelle and Carole LaRochelle's training and education. I have discussed with Carole LaRochelle the nature of the services to be provided. I understand that Carole LaRochelle is not a licensed physician and that Rolfing services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself/my child with a medical doctor. I have consented to use the services offered by Carole LaRochelle, and agree to be personally responsible for the fees of Carole LaRochelle in connection with the services provided to me.

Signed: \_\_\_\_\_  
(client/parent/conservator/guardian)

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

Indicate capacity to sign if other than client \_\_\_\_\_

**I welcome referrals, which signify your satisfaction and trust in my services.**