



## VETERANS WELLNESS 2018 RETREAT APPLICATION

### PERSONAL INFORMATION (All personal information is confidential and treated accordingly.)

Service Member/Veteran Name\* \_\_\_\_\_ DOB\* \_\_\_\_\_  
Last 4 digits of SSAN \_\_\_\_\_ Ethnicity \_\_\_\_\_ Tribal Affiliation \_\_\_\_\_  
Name of Spouse/Partner\* \_\_\_\_\_ DOB\* \_\_\_\_\_  
Last 4 digits of SSAN \_\_\_\_\_ Ethnicity \_\_\_\_\_ Tribal Affiliation \_\_\_\_\_  
Relationship to Veteran if not spouse\* \_\_\_\_\_  
What first name would you like on your nametag? Veteran \_\_\_\_\_ Partner \_\_\_\_\_  
Veteran Home Address\* \_\_\_\_\_  
City\* \_\_\_\_\_ State\* \_\_\_\_\_ Zip Code\* \_\_\_\_\_  
Number of Children \_\_\_\_\_ Ages/Gender \_\_\_\_\_  
Home Phone\* \_\_\_\_\_ Vet Cell Phone \_\_\_\_\_ Partner Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Employment Status: \_\_\_\_\_ Living Situation \_\_\_\_\_

### SERVICE INFORMATION

Branch of Service\* \_\_\_\_\_ Service Years\* \_\_\_\_\_ Discharge Date\* \_\_\_\_\_  
Combat Zone(s) \_\_\_\_\_ Deployment Dates \_\_\_\_\_  
Name of MOS/AFSC \_\_\_\_\_  
Awards/Decorations \_\_\_\_\_  
Current Status:\*  Active Duty  Military Retired  Veteran  Other: \_\_\_\_\_

**Is your Spouse/Partner a military veteran?\*** Yes \_\_\_ No \_\_\_

If so, please provide the following:\*

Branch of Service \_\_\_\_\_ Service Years \_\_\_\_\_ Discharge Date \_\_\_\_\_  
Combat Zone(s) \_\_\_\_\_ Deployment Dates \_\_\_\_\_  
Name of MOS/AFSC \_\_\_\_\_  
Awards/Decorations \_\_\_\_\_  
Current Status:  Active Duty  Military Retired  Veteran  Other: \_\_\_\_\_

**\* Required information.**

## POST TRAUMATIC STRESS (PTS) INFORMATION

**The Veteran must have been diagnosed with PTS to attend a retreat.**

Veterans PTS was diagnosed: Date/Year\* \_\_\_\_\_  VA What VA Facility?\* \_\_\_\_\_

If not VA, what Clinic or Professional Health Care Provider?\* \_\_\_\_\_

Current/Past Counseling:\* \_\_\_\_\_

**Has your Spouse/Partner been diagnosed with PTS?** Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please answer the following questions and complete the PTS questionnaire at the end of the application:

PTS was diagnosed: Date/Year \_\_\_\_\_  VA What VA Facility? \_\_\_\_\_

If not VA, what Clinic or Professional Health Care Provider? \_\_\_\_\_

Current/Past Counseling: \_\_\_\_\_

## VETERAN PTS SYMPTOM QUESTIONNAIRE

**Veteran Participant's Name\*** \_\_\_\_\_ **Date\*** \_\_\_\_\_

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then circle/check one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. Make sure to base your answers on problems

that started or got worse after the event. **The event you experienced was** \_\_\_\_\_

**(Name event) in** \_\_\_\_\_ **(month/year when event occurred)**. Indicate how much were you bothered by each item in the last month. As a guide: Extremely might mean almost every day; Quite a Bit might mean twenty days out of the past 30; Moderately might mean ten to fourteen days; and A Little Bit might mean any number of days less than ten days out of the last 30. If you were not bothered by the indicated problem at all during the last 30 days, select Not at All.

**\* Required information.**

**VETERAN PTS SYMPTOM QUESTIONNAIRE (Continued)\***

Participant ID # \_\_\_\_\_ (Center Use Only)

|           | <b>Response</b>   | <b>Not At All</b> | <b>A Little Bit</b> | <b>Moderately</b> | <b>Quite A Bit</b> | <b>Extremely</b> |
|-----------|---|-------------------|---------------------|-------------------|--------------------|------------------|
| <b>1</b>  | Repeated, disturbing, and unwanted memories of the stressful experience?  |                   |                     |                   |                    |                  |
| <b>2</b>  | Repeated, disturbing dreams of the stressful experience?  |                   |                     |                   |                    |                  |
| <b>3</b>  | Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?   |                   |                     |                   |                    |                  |
| <b>4</b>  | Feeling very upset when something reminded you of the stressful experience?   |                   |                     |                   |                    |                  |
| <b>5</b>  | Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?  |                   |                     |                   |                    |                  |
| <b>6</b>  | Avoiding memories, thoughts, or feelings related to the stressful experience?   |                   |                     |                   |                    |                  |
| <b>7</b>  | Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or  |                   |                     |                   |                    |                  |
| <b>8</b>  | Trouble remembering important parts of the stressful experience (for some reason besides a head injury or alcohol   |                   |                     |                   |                    |                  |
| <b>9</b>  | Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? |                   |                     |                   |                    |                  |
| <b>10</b> | Blaming yourself or someone else (who didn't directly cause the event or actually harm you) for the stressful experience or what happened after it?   |                   |                     |                   |                    |                  |
| <b>11</b> | Having strong negative feelings such as fear, horror, anger, <b>guilt, or shame?</b>  |                   |                     |                   |                    |                  |
| <b>12</b> | Loss of interest in activities that you used to enjoy?  |                   |                     |                   |                    |                  |
| <b>13</b> | Feeling distant or cut off from other people?   |                   |                     |                   |                    |                  |
| <b>14</b> | Having trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?  |                   |                     |                   |                    |                  |
| <b>15</b> | Feeling irritable or angry or acting aggressively?  |                   |                     |                   |                    |                  |
| <b>16</b> | Taking too many risks or doing things that could cause you  |                   |                     |                   |                    |                  |
| <b>17</b> | Being "super alert" or watchful or on guard?  |                   |                     |                   |                    |                  |
| <b>18</b> | Feeling jumpy or easily startled?   |                   |                     |                   |                    |                  |
| <b>19</b> | Having difficulty concentrating?  |                   |                     |                   |                    |                  |
| <b>20</b> | Trouble falling or staying asleep?  |                   |                     |                   |                    |                  |

**\* Required information.**

## PARTNER / SUPPORT PERSON PTS SYMPTOM QUESTIONNAIRE

**Partner/Support Person Name\*** \_\_\_\_\_ **Date\*** \_\_\_\_\_

The purpose in having you to join your veteran is not only for you to help provide support and healing to them, but also to provide a healing opportunity for you. Our focus throughout the retreat will be to meet the needs of both you and your partner equally.

To help us do this, we would like to understand the degree to which you might be experiencing symptoms of stress in your life whether the symptoms result from your own history of trauma, the normal stresses of life, or from your relationship with someone who has PTS. Please answer the two questions below, and complete the attached PTS questionnaire.

Where the questionnaire uses the term “the stressful experience”, you may answer according to a specific experience you have had or to the overall stress you experience in your life.

Before you complete the questionnaire, please answer the following questions:

1. On average, to what degree do you experience normal stress/distress? 0-10 (0 = none; 10 = extreme) \_\_\_\_\_
2. Have you had an experience(s) where you felt your ethics (your sense of right and wrong) was strongly violated, resulting in a significant sense of self-blame, shame, confusion, anger/rage or depression? \_\_\_\_\_

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then circle/check one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. Make sure to base your answers on problems that started or got worse after the event. **The event you experienced was** \_\_\_\_\_

**(Name event) in** \_\_\_\_\_ **(month/year when event occurred)**. Indicate how much were you bothered by each item in the last month. As a guide: Extremely might mean almost every day; Quite a Bit might mean twenty days out of the past 30; Moderately might mean ten to fourteen days; and A Little Bit might mean any number of days less than ten days out of the last 30. If you were not bothered by the indicated problem at all during the last 30 days, select Not at All.

**\* Required information.**

**PARTNER / SUPPORT PERSON PTS SYMPTOM QUESTIONNAIRE (Continued)\***

Participant ID # \_\_\_\_\_ (Center Use Only)

|           | <b>Response</b>   | <b>Not At All</b> | <b>A Little Bit</b> | <b>Moderately</b> | <b>Quite A Bit</b> | <b>Extremely</b> |
|-----------|---|-------------------|---------------------|-------------------|--------------------|------------------|
| <b>1</b>  | Repeated, disturbing, and unwanted memories of the stressful experience?  |                   |                     |                   |                    |                  |
| <b>2</b>  | Repeated, disturbing dreams of the stressful experience?  |                   |                     |                   |                    |                  |
| <b>3</b>  | Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?   |                   |                     |                   |                    |                  |
| <b>4</b>  | Feeling very upset when something reminded you of the stressful experience?   |                   |                     |                   |                    |                  |
| <b>5</b>  | Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?  |                   |                     |                   |                    |                  |
| <b>6</b>  | Avoiding memories, thoughts, or feelings related to the stressful experience?   |                   |                     |                   |                    |                  |
| <b>7</b>  | Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities,  |                   |                     |                   |                    |                  |
| <b>8</b>  | Trouble remembering important parts of the stressful experience (for some reason besides a head injury or   |                   |                     |                   |                    |                  |
| <b>9</b>  | Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? |                   |                     |                   |                    |                  |
| <b>10</b> | Blaming yourself or someone else (who didn't directly cause the event or actually harm you) for the stressful experience or what happened after it?   |                   |                     |                   |                    |                  |
| <b>11</b> | Having strong negative feelings such as fear, horror, anger, guilt, or shame?   |                   |                     |                   |                    |                  |
| <b>12</b> | Loss of interest in activities that you used to enjoy?  |                   |                     |                   |                    |                  |
| <b>13</b> | Feeling distant or cut off from other people?   |                   |                     |                   |                    |                  |
| <b>14</b> | Having trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?  |                   |                     |                   |                    |                  |
| <b>15</b> | Feeling irritable or angry or acting aggressively?  |                   |                     |                   |                    |                  |
| <b>16</b> | Taking too many risks or doing things that could cause you  |                   |                     |                   |                    |                  |
| <b>17</b> | Being "super alert" or watchful or on guard?  |                   |                     |                   |                    |                  |
| <b>18</b> | Feeling jumpy or easily startled?   |                   |                     |                   |                    |                  |
| <b>19</b> | Having difficulty concentrating?  |                   |                     |                   |                    |                  |
| <b>20</b> | Trouble falling or staying asleep?  |                   |                     |                   |                    |                  |

**\* Required information.**

## MEDICAL INFORMATION

### VETERAN:

Service connected disability: % \_\_\_\_\_ Condition/Basis \_\_\_\_\_

Prescription Medications: \_\_\_\_\_

**NOTE: The nearest pharmacy is 35 miles away so bring at least an 8-day supply of prescription medications.**

**VETERAN** Physical Conditions that require assistance/unique accommodations:  Motorized Wheelchair

Wheelchair  Walker  Cane  Other: \_\_\_\_\_

Medical Conditions:  Diabetic  Oxygen  Nebulizer  CPAC or other similar equipment. Other Medical Conditions: \_\_\_\_\_

Sensitivities or Allergies:  Smoke  Other: \_\_\_\_\_

Dietary:  Vegetarian  Vegan  Gluten Free  Other: \_\_\_\_\_

Service Animal: Purpose \_\_\_\_\_ Certified? Yes  No  Breed: \_\_\_\_\_

### **PARTNER:**

Service connected disability (if also Veteran): % \_\_\_\_\_ Condition/Basis \_\_\_\_\_

Prescription Medications: \_\_\_\_\_

Physical Conditions that require assistance/unique accommodations:  Motorized Wheelchair

Wheelchair  Walker  Cane  Other: \_\_\_\_\_

Medical Conditions:  Diabetic  Oxygen  Nebulizer  CPAC or similar equipment

Other: \_\_\_\_\_

Sensitivities or Allergies:  Smoke  Other: \_\_\_\_\_

Dietary:  Vegetarian  Vegan  Gluten Free  Other: \_\_\_\_\_

Service Animal: Purpose \_\_\_\_\_ Breed \_\_\_\_\_

**\* Required information.**

**RETREAT INFORMATION**

**Participants should arrive at the retreat location between the hours of 12:00 PM and 3:00 PM. Travel will be paid by the participant. The Retreat does not cover any travel expenses. Lodging and meals will be provided at no cost to the participants. Due to the nature of these retreats, children are not allowed to attend. Comfortable, casual attire such as jeans, shorts, tennis shoes, bathing suits, hats and sunscreen are recommended. Closed toed shoes are necessary for equine therapy. Some activities will require exercise or loose clothing. Cool evening temperatures are expected and sweaters and light jackets are appropriate. Participants should bring pants or ankle length skirts for Native American ceremonies. We also have an evening dinner with dancing, please bring appropriate clothing.**

We conduct Equine Therapy on the first full day of the retreat followed by a very mellow horseback. We want to ensure we have the right number of saddled horses. Please indicate if you think you might do the horseback ride. If you are unsure, just mark "Horse Back Ride"

Veteran Horse Back Ride? Yes  No  If "Yes," Height: \_\_\_\_\_feet \_\_\_\_\_ inches. Weight: \_\_\_\_\_ lbs.

Partner Horse Back Ride? Yes  No  If "Yes," Height: \_\_\_\_\_feet \_\_\_\_\_ inches. Weight: \_\_\_\_\_ lbs.

**IF YOU A SINGLE VETERAN WHO HAS NO PARTNER**, but would be willing to partner with another vet who has completed the retreat and can mentor you during and after your retreat, please indicate below.

Yes, I would like a another Veteran to be your PTS support person during and after the retreat.

No, I do not want a Veteran support person during and after the retreat. I will continue to seek a partner before my retreat.

For questions relative to the Retreat Application process, please call (575) 377-5236.

Once your application has been received and processed, you will be notified and placed in one of our first available scheduled retreats. See Center webpage ([www.veteranswellnessandhealing.org](http://www.veteranswellnessandhealing.org)) for retreat schedule. If circumstances require a particular retreat start date, please indicate below. **Availability is limited.**

1<sup>st</sup> Choice \_\_\_\_\_

2<sup>nd</sup> Choice: \_\_\_\_\_

Mail the entire completed Retreat Application to:  
National Veterans Wellness and Healing Center  
PO Box 805  
Angel Fire, New Mexico 87710

Email scanned applications to [application@veteranswellnessandhealing.org](mailto:application@veteranswellnessandhealing.org).

We have read the entire application and believe all of the answers given on the Retreat Application are true and correct. We have also read the Center’s health information privacy practices.

\_\_\_\_\_  
Signature of Service Member/Veteran\*

\_\_\_\_\_  
Date \*

\_\_\_\_\_  
Signature of Spouse/Partner\*

\_\_\_\_\_  
Date \*

**How did you hear about the National Veterans Wellness and Healing Center?** \_\_\_\_\_

## NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

### PLEASE REVIEW IT CAREFULLY

If you have any question about this notice, please contact the National Veterans Wellness and Healing Center's ("Center") Privacy Officer.

#### **This Notice Describes Our Practice and those of:**

Any Center contracted provider or staff that provide services to you or any volunteer the Center allows to help you during your retreat. All of these people follow the terms of this notice. They may also share protected health information with each other for services provided or other retreat-related operations described in this notice.

#### **Our Pledge Regarding Health Information:**

We understand that health information about you and your health is personal. Your health information is contained in a record that is the physical property of the Center. We are committed to protecting health information about you. This notice will tell you about the ways in which we may use and disclose health information. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

#### **The Center is required by law to:**

Make sure that medical information that identifies you is private. Give you this notice of our legal duties and privacy practices with respect to health information about you. Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations. Follow the terms of the notice that is currently in effect.

#### **How the Center may use or disclose your health information:**

**For Retreat Services.** The Center may use your health information to provide you with services. For example, a provider, such as a counselor, may record information in your record that is necessary for your successful retreat experience. This information is necessary for the provider to determine what service you should receive.

Providers may also record actions taken by them or other retreat providers in the course of the retreat and note how you respond to the actions. Your information may also be used for aftercare following the retreat.

**For Retreat Operations.** The Center may use and disclose health information for operational purposes. For example, your health information may be disclosed to members of the retreat staff or Center volunteers to assign counselors, evaluate the performance of our providers, assess the quality of service and outcomes, learn how to improve our facilities and services, and determine how to continually improve the quality and effectiveness of the retreats.

**For Post Traumatic Stress related activities.** The Center may use your information to contact you to provide reminders and information of your scheduled retreat. The Center may also contact you about services, activities, or health-related benefits that may be of interest to you.

**Others involved in your care.** The Center may release relevant health information to a family member, friend, or anyone else you designate in order for that person to be involved in your care or aftercare.

**Outreach to other Veteran Families.** The Center will not release any health information for the purpose of informing and educating others in the military and veteran community about Post Traumatic Stress and the Center's programs without your written authorization.

**Fundraising:** The Center will not release any health information for the purpose of fundraising without your written authorization.

**Required by law.** The Center may use and disclose information about you as required by law. For example, the Center may disclose information to report suspected abuse or neglect, or similar injuries or events.

**Law enforcement purpose.** Subject to certain restrictions we may disclose information required by law officials.



**Judicial and administrative proceedings.** We may disclose information in response to an appropriate subpoena, discovery request or court order.

**Health oversight activities.** We may disclose your health information to a health oversight agency for activities authorized by law.

**Research.** We may use your health information for research purposes after a receipt of authorization from you.

**Health and safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

**Other uses and disclosures.** Other uses and disclosures will be made only with your written authorization. You may revoke an authorization except to the extent that the Center has taken action reliant on it.

**Your health information rights:**

You have the right to:

- Obtain a paper copy of this notice of information practice upon request.
- Inspect and obtain a copy of our health information practices upon request.
- Request an amendment to your health information that is maintained by the Center.
- Request confidential communications of your health information by alternative means or at alternative locations.
- Receive an accounting of disclosures made of your health information. Request a restriction on certain uses and disclosures of your information. The Center is not required to agree to a requested restriction.

**Changes to this notice:** The Center reserves the right to change the terms of this notice. The Center can make the new terms effective for all protected health information kept by the Center. You may also get a current copy by contacting the Center Privacy Officer.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the Center Privacy Officer or with the Secretary for the Department of Health and Human Services. To file a complaint with the Center, submit your written complaint to our Privacy Officer. You will not be penalized for filing and complaint.

**Contact information for questions or to file a complaint:** If you have any question about this notice, want to exercise one of our rights that are described in the notice, or want to file a complaint, please contact the Center Privacy Officer at the National Veterans Wellness and Healing Center, PO Box 805, Angel Fire, NM 87710.





## **PARTICIPATION AGREEMENT**

This Participation Agreement sets forth the terms and understanding between the National Veterans Wellness and Healing Center (NVWHC) and participants of the NVWHC seven-day PTS Couples Retreat Program.

### **Background**

Our staff is whole-heartedly committed to providing you and your partner with a safe environment that promotes both healing and personal growth. Establishing and maintaining a safe and stable environment is one of the most critical parts of our program and is the foundation that our week-long program is built upon.

### **Purpose**

The purpose of this Memorandum of Understanding is to provide all retreat participants and staff members with some very basic rules or guidelines that must be acknowledged and followed as a condition of this program. The rules and guidelines laid out below have been established as critical to maintaining a safe and stable environment for both the participants as well as staff members.

### **Firearms and Weapons**

- We respect your 2<sup>nd</sup> amendment rights however the carrying or storing of any weapon or firearm in retreat facilities is strictly prohibited. Firearms and other weapons should be stored in your personally-owned vehicle for the duration of the retreat and are not permitted within retreat facilities for any reason. Retreat facilities include but are not limited to hotel, therapy rooms, conference rooms, equine facilities, dining facilities, etc.
- We ask you to commit to keeping weapons and firearms out of retreat facilities.
- Firearms are prohibited on Angel Fire Resort Food and Beverage venues.

### **Alcohol and Recreational Drugs**

- Alcohol consumption and recreational drug usage are prohibited in our program. This rule does not apply to drugs that have been medically prescribed by a licensed doctor or physician. If you believe that adhering to this rule could create a medical issue or raises concerns for you, please address this concern privately with Retreat Program Director or Facilitator.
- We ask that you commit to refraining from alcohol consumption and recreational drug use during this retreat.
- Outside alcohol is not permitted via NM laws on Angel Fire Resort Property.

### **Participation**

- Our retreat program is voluntary and the only associated cost to you and your partner is your participation. It is one of the most important factors in whether or not you will find this experience beneficial and productive. Participants are expected to attend all scheduled activities outlined in his / her personal retreat schedule.
- We ask that you pay close attention to the schedule provided to you and that you are on time for all activities and appointments

- As a courtesy, if a scheduled activity creates a conflict for you and you cannot attend an activity or appointment due to medical or personal reasons, please privately notify the Executive Director, Retreat Program Director or Facilitator prior to your scheduled appointment time or activity. By notifying one of above staff members in advance, we can notify staff of your absence and prevent timely searching for individuals. Early notification can also create an opportunity for another individual to be treated during your absence. We ask that you commit to notifying our staff if you cannot be present for or participate in an activity / appointment and that you are on time.

**Respect and Consideration**

- We ask that you remain considerate of others this week and respectful towards every veteran, spouse, family member, friend or staff member who is also participating in this program. In addition to these individuals, we must also be considerate and respectful of the thoughts, opinions, emotions, or feelings of others as well.
- Articles of clothing that could be distracting for the group or viewed as derogative or offensive in nature are not permitted for wear during this retreat.
- Sharing or displaying of inappropriate materials such as pornography or other items that could be viewed as offensive in nature are not permitted during this retreat.
- We ask that you commit to being respectful and considerate while participating in this retreat.

**Cellphones, Tablets, Mobile Devices**

- The use of cellphones during scheduled activities or appointments is prohibited. We ask that you keep your cellphone, tablets, and other mobile devices on silent mode and stored away during all activities and appointments.
- If you have a special circumstance that may require the use of your mobile device during activity or appointment periods, please privately notify the Retreat Program Director or Facilitator and inform them of your special circumstances. To prevent distractions from occurring, we all participants with special circumstances that require access to a cellphone or mobile devices to ensure that these devices remain on vibrate and that he or she steps out prior to using this device.
- We ask that you commit to following our cellphone & mobile device policy.

As previously mentioned, the topics discussed in this MOU are critical to maintaining a safe and healthy environment and we greatly appreciate your willingness to comply with these terms. The National Veterans Wellness and Healing Center reserves the right to dismiss any participant who fails to comply with these terms and conditions.

Congratulations on your decision to join us for what we can only hope is a life-changing experience for you and your partner. We are humbled you have chosen The National Veterans Wellness and Healing Center to be a part of your healing and appreciate the opportunity of serving you.

I agree to the terms & conditions set forth herein.

**Participant #1**  
**Print Name** \_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date** \_\_\_\_\_

**Participant #2**  
**PrintName** \_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date** \_\_\_\_\_