Consent Form

I understand that Susan Duke LLC (Susan Duke DO and Susan Duke) supports the body's natural ability to heal with alternative healing treatments such as cranial therapy, energy healing and osteopathy.

I understand that Susan Duke does not practice traditional allopathic style medicine.

I understand that Susan Duke does not offer comprehensive services such as acute wound, fracture, or trauma care, and is not a primary care provider. It is important for me to maintain a relationship with my primary care provider.

I understand that my condition can progress or worsen, despite alternative healing treatment. Symptoms may or may not lessen with this treatment.

I acknowledge that I have read this document and received no guarantees, warranties, or assurances as to the results that may be obtained from Susan Duke.

I hereby authorize Susan Duke to perform cranial therapy, energy healing and osteopathy. I recognize that I may withdraw my consent at any time.

By signing below I acknowledge that I have read, understand, and agree with these terms and conditions.

Client/Responsible Party Date

_____ _____

Susan Duke Date

_____ _____