Hypnosis Columbia LLC

5570 Sterrett Place, Suite 310,
Columbia, MD 21044
hypnosiscolumbia@gmail.om
(443) 686-9645

Physician/Medical Referral Form

Attention:_____

I, Racquel A. Knight, am a trained and certified consulting hypnotist and owner of Hypnosis Columbia LLC. I am an active member and in good standing with The National Guild of Hypnotists. Also, as part of my professional and ethical obligations, I complete annual continuing education to maintain my proficiencies at the highest level and in accordance to the rules and regulations of The National Guild of Hypnotists. I have specialized experience and training in **Pain Management, Addiction Recovery Support/Relapse Prevention, Weight Management and Neuro-linguistic Programming.**

My business Hypnosis Columbia LLC is registered in the State of Maryland and is located at 5570 Sterrett Place, Suite 310, Columbia, Maryland 21044.

Your patient:_____

has requested my help and assistance in the area of:

_____

Hypnotism is not, at this time, licensed by state governments, and is a self-regulating profession of certified practitioners. I am neither a physician nor a licensed health care provider, and I do not provide medical diagnosis or medical treatment for illness, disease or mental disorders of any kind. Hypnotism works as a compliment and in conjunction with the medical health care system and the client's medical team when necessary. Hypnotism is a mental conditioning process that will allow your patient to use the natural and normal faculties of their own mind to create desired and positive changes and health in their life.

Your signature below authorizes me to help and guide the above named patient through the techniques of hypnosis for the purpose described above. Please include your address and telephone number, so that I may inform you of your patient's progress. Thank you.

Racquel A. Knight

Certified Consulting Hypnotist
Certified Relapse Prevention Specialist

Date: _____

Physician Signature:_____

Physician Telephone Number: _____

Physician Address: _____

Patient Signature:

_____

If patient under 18 years if age, parent or guardian signature:

_____