Lorraine Storm, MS, LPC
Health Counseling PDX

ASSUMPTION OF RISK & LIABILITY RELEASE- **WALKING THERAPY**

Please read the following items pertaining to assumption of risk and liability release, in connection with Walking Therapy with Lorraine Storm, MS, LPC.

For purposes of this document, Walking Therapy refers to psychotherapy while walking and takes place outdoors in public places.

I voluntarily choose to participate in Walking Therapy with Lorraine Storm, MS, LPC, because I believe it may be helpful to my own personal growth and development. In so doing, I expressly accept the risks of Walking Therapy and its individual activities and processes.

I understand that participating in Walking Therapy is my choice, provided as an alternative to in-office therapy sessions, and that I may discontinue Walking Therapy at any time and for any reason.

I understand that my relationship with Lorraine Storm, MS, LPC is that of client and therapist and is completely professional.

I recognize that Lorraine Storm, MS, LPC will be acting as my mental health therapist and will be operating under the scope of that particular license; not as a fitness trainer or in any other capacity.

I understand the risks associated with Walking Therapy, inherent and otherwise. I attest that I have no known health problems or medical conditions which could in any way limit my ability to safely participate in Walking Therapy and I assume all health risks associated with this activity. I further understand the risks associated with general outdoor activity, and the hazards that may be presented by natural causes or acts of other persons or animals, whether negligent or intentional.

Because Walking Therapy is held outdoors, in public places, I understand that Lorraine Storm, MS, LPC cannot guarantee the confidentiality of the information I choose to disclose during such activities, including but not limited to: the possibility that I may encounter another person I know, the therapist may encounter another person she knows, or another person may overhear what I or my therapist says while I am participating in Walking Therapy, and/ or my therapist may be recognized by others as a therapist.

I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating in or present at Walking Therapy, or else I agree to bear the costs of such injury or damage to myself.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client Signature Date

_____

Client Printed Name

_____ _____

Therapist: Lorraine Storm, MS, LPC Date