

KAP CONSENT: THERAPEUTIC TOUCH

This consent form covers the agreement between the client and KAP provider(s) listed below, and no other persons present during the KAP medicine session. There may be other instances of incidental touch, such as helping the client walk or steady themselves, provided by other assistants in the clinical setting. This consent covers intentional therapeutic touch.

_____ I have discussed the option of being offered touch during my psychedelic session and have decided I do/do not want to be touched during the session.

_____ I understand if I have said I do not want to be touched I cannot change my mind for the current session during the session.

_____ I understand that if I have said I do want to be offered touch during my session, I can change my mind at any time and those wishes will be honored.

_____ I have participated in a touch-refusal exercise to practice saying I do not want to be touched.

The ways I have communicated that I do and do not want to be touched are reflected below.
(Examples include the therapist holding your hand, holding your feet, laying their hands on your head or arm)

Name of Client	Date
----------------	------

Name of KAP Provider	Date
----------------------	------

Name of Additional KAP Provider	Date
---------------------------------	------