Client Consent Form

PLEASE PRINT LEGIBLY. YOUR INFORMATION IS CONFIDENTIAL.

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Cell Phone: _____

Referred by:_____

In case of emergency, please notify:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

I hereby request and consent to treatment or services to be performed by Elite Sports Therapy & Wellness, LLC staff and give the treating party permission and authority to treat me in ways that are judged beneficial to me based on physical tests and analysis. I understand that results are not guaranteed and I am aware that there are some risks to treatment.

It is the responsibility of the patient to disclose any underlying physical defects, illnesses, or deformities that may not otherwise come to the attention of the treating party and that may render the patient susceptible to injury. The treating party will not provide treatment if he/she is made aware of adverse conditions as stated above.

My signature below certifies that I have read and understand the above information regarding informed consent.

I have read and understood the terms outlined above and consent to all necessary treatment as determined by Elite Sports Therapy and Wellness, LLC.

_____ _____

Signature of patient or responsible party Date

_____ _____

Participant Parent or Legal Guardian
If participant is under the age of 18

Signature