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 Signature

If participant is under the age of 18