Ally for Acupuncture, LLC – Alexandra Feldman

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 Ally for Acupuncture, LLC and give Alexandra Feldman permission and authority to help 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 soft tissue therapy and rehabilitation.

It is the responsibility of the client 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 client susceptible to injury. The treating party will not provide therapy if he is made aware of adverse conditions as stated above.

There will be no refunds of any fees paid for these services.

My signature below certifies that I have read and understood the terms outlined above and consent to all necessary therapy as determined by Ally for Acupuncture, LLC.

_______________________________________ _______________________

Signature of patient or responsible party Date

_______________________________________ _______________________

Participant Parent/Legal Guardian Signature

April2019