HANDS ON HEALING

CLIENT INFORMATION

Legal name: _____ Nickname: _____
(PLEASE PRINT)

Date of birth: _____
(MONTH / DAY/ YEAR)

Street Address: _____

City: _____ State: _____ Zip: _____

Primary telephone number: _____Alternate number:_____

Your email address if I need to contact you. ***It will not be shared with anyone.***

_____@_____
(PLEASE PRINT)

Emergency contact:

Name: _____ Relationship: _____

Telephone number: _____

PAYMENT / CANCELLATION / NO –SHOW POLICY

Full payment by check or cash is expected at the time of treatment. I will give you a receipt with the necessary information to file insurance or for tax purposes, but I do not accept insurance or file with insurance companies.

Please give 24 hours notice if you must cancel an appointment. There is a **$75.00 charge** for a late cancellation or failure to keep an appointment.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

BY SIGNING BELOW, I authorize and request John Leonard, PT, LMBT, to perform any appropriate treatment and / or services related to my condition. This consent is effective from the date it is executed until the date the client terminates it in writing.

Signature: _____ Date: _____