



**Total Body Therapy & Wellness**  
PATIENT INFORMATION SHEET

<b>FIRST NAME</b>		<b>LAST NAME</b>	<b>MIDDLE INITIAL</b>	<b>SSN</b>
<b>MALE</b>	<b>DATE OF BIRTH</b> (MM/DD/YYYY)	<b>MARTIAL STATUS</b> SINGLE MARRIED SEPARATED DIVORCED WIDOWED	<b>EMPLOYMENT</b> EMPLOYED UNEMPLOYED RETIRED STUDENT	<b>EMAIL ADDRESS</b>
<b>FEMALE</b>				
<b>HOME PHONE (PRIMARY YES/NO)</b> _____		<b>CELLPHONE (PRIMARY YES/NO)</b> _____		<b>APPOINTMENT REMINDER PREFERENCE</b> ____ TEXT MESSAGE ____ EMAIL ____ PHONE CALL

<b>MAILING ADDRESS</b>	<b>APT #</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>
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<b>WHY ARE YOU BEING SEEN TODAY? LEFT RIGHT BOTH</b> _____	<b>IS THIS A WORKER'S COMPENSATION CASE?</b>  YES NO	<b>DO YOU HAVE A LAWYER REPRESENTING YOU FOR THIS INJURY?</b>  YES NO <b>IF SO, DO YOU HAVE HEALTH INSURANCE?</b>  YES NO	<b>ARE YOU RECEIVING HOME HEALTHCARE OF ANY KIND?</b>  YES NO	<b>ARE YOU EXPERIENCING ANY FOOT RELATED ISSUES?</b>  YES NO
<b>WHEN DID YOUR SYMPTOMS BEGIN?</b> _____				

<b>IS THIS INJURY A RESULT OF A MOTOR VEHICLE ACCIDENT?</b> YES NO  IF YES... <b>WHAT STATE DID THE ACCIDENT OCCUR?</b> _____  <b>WHAT WAS THE DATE OF ACCIDENT?</b> _____  <b>WERE YOU HOSPITALIZED DUE TO THE ACCIDENT?</b> YES NO <b>IF SO, WHAT DATES?</b> _____  <b>WERE YOU UNABLE TO WORK DUE TO THE ACCIDENT?</b> YES NO <b>IF SO, WHAT DATES?</b> _____	<b>PRIMARY CARE PROVIDER:</b> _____  <b>REFERRING PHYSICIAN:</b> _____
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<b>HOW DID YOU HEAR ABOUT TBTW?</b>  WORKSHOP REFERRAL WALK-IN REFERRAL INTERNET SEARCH NEWSLETTER OTHER: _____ FRIEND/FAMILY FACEBOOK PHYSICIAN FORMER PATIENT LAWYER	<b>EMPLOYER:</b> _____  <b>EMPLOYER ADDRESS:</b> _____ _____  <b>EMPLOYER PHONE:</b> _____
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EMERGENCY CONTACT					
<b>RELATIONSHIP TO PATIENT</b>	<b>FIRST NAME</b>	<b>LAST NAME</b>	<b>PHONE NUMBER</b>	<b>EMAIL ADDRESS</b>	<b>THIS PERSON HAS PERMISSION TO DISCUSS MEDICAL RECORDS FOR THE PATIENT?</b>  YES NO
<b>ADDRESS (IF DIFFERENT FROM PATIENT)</b>	<b>APT #</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	

## MEDICAL HISTORY

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

**EXISTING OR RELEVANT PREVIOUS CONDITION (PLEASE CIRCLE APPROPRIATE ANSWER)**

ALLERGIES	YES	NO	DIZZY SPELLS	YES	NO	MRSA	YES	NO
ANEMIA	YES	NO	EMPHYSEMA	YES	NO	MULTIPLE SCHLEROSIS	YES	NO
ANXIETY	YES	NO	EXCESSIVE FATIGUE	YES	NO	MUSCULAR DISEASE	YES	NO
ARM/LEG SWELLING	YES	NO	EXCESSIVE WEAKNESS	YES	NO	NUMBNESS/TINGLING	YES	NO
ARTHRITIS	YES	NO	FIBROMYALGIA	YES	NO	OSTEOPOROSIS	YES	NO
ASTHMA	YES	NO	FRACTURES	YES	NO	PARKINSONS	YES	NO
AUTOIMMUNE DISORDER NAME: _____	YES	NO	FREQUENT URINATION	YES	NO	RHEUMATOID ARTHRITIS	YES	NO
BLOOD IN URINE OR STOOLS	YES	NO	GALLBLADDER PROBLEMS	YES	NO	SEIZURES	YES	NO
BRUISE EASILY	YES	NO	HEADACHES	YES	NO	SEXUAL DIFFICULTIES	YES	NO
CANCER	YES	NO	HEARING IMPAIRMENT	YES	NO	SKIN RASH	YES	NO
CARDIAC CONDITIONS	YES	NO	HEPATITIS	YES	NO	SMOKING	YES	NO
CARDIAC PACEMAKER	YES	NO	HIGH CHOLESTEROL	YES	NO	SPEECH PROBLEMS	YES	NO
CHEMICAL DEPENDENCY	YES	NO	HIGH/LOW BLOOD PRESSURE	YES	NO	STRESS AT HOME OR WORK	YES	NO
CIRCULATION PROBLEMS	YES	NO	HIV/AIDS	YES	NO	STROKES	YES	NO
CURRENTLY PREGNANT	YES	NO	INCONTINENCE	YES	NO	THYROID DISEASE	YES	NO
DEPRESSION	YES	NO	KIDNEY PROBLEMS	YES	NO	TREMORS	YES	NO
DIABETES	YES	NO	METAL IMPLANTS	YES	NO			

**DESCRIBE ANY OTHER CONDITIONS** (IF "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN AND GIVE APPROXIMATE DATES):

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**FALL HISTORY:**

INJURY AS A RESULT OF A FALL IN THE PAST YEAR?    **YES**                      **NO**  
 TWO OR MORE FALLS IN THE LAST YEAR?            **YES**                      **NO**  
 PATIENT IS AT RISK FOR FALLS?                      **YES**                      **NO**

**SURGICAL HISTORY** (PLEASE INCLUDE DATE OR BEST ESTIMATE):

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**PLEASE CHECK IF YOU HAVE BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING WITHIN THE PAST MONTH:**

	LOW BACK AND RADIATING PAIN		ELBOW PAIN OR INSTABILITY		NUMBNESS, TINGLING, OR BURNING SENSATION IN THE ARMS OR HANDS
	NUMBNESS, TINGLING OR BURNING SENSATION IN THE LEGS OR FEET		BLURRED VISION		LOSS OF SENSATION IN HANDS/FEET
	WEAKNESS IN THE LEGS OR ARMS		DIZZINESS OR VERTIGO		DAILY ALCOHOL 3 GLASSES OR MORE
	YOU HAVE DIABETES OR NEUROPATHY		UNSTEADY GAIT		MUSCLE DISEASE/MUSCLE CRAMPING
	THYROID DYSFUNCTION		HYPERTENSION		SHOULDER PAIN OR INSTABILITY
	TENDINITIS/BURSITIS/ARTHRITIS		NECK PAIN AND RADIATION PAIN		ANKLE-FOOT PAIN OR INSTABILITY
	HEARING PROBLEMS		HEADACHES		HISTORY OF FALLS
	HYPOTENSION				

**INFORMED CONSENT**

LASER THERAPY IS A SAFE, NON-INVASIVE, FDA CLEARED MODALITY FOR THE TREATMENT OF PAIN AND THE TEMPORARY INCREASE OF MICROCIRCULATION. INCREASED MICROCIRCULATION CAN PROVIDE RELIEF FOR MANY ACUTE AND CHRONIC CONDITIONS. LASER THERAPY UTILIZES VISIBLE AND INVISIBLE LASER RADIATION; THEREFORE, APPROPRIATE EYE PROTECTION IS REQUIRED AT ALL TIMES DURING TREATMENT.

EFFECTS OF YOUR TREATMENT WILL CONTINUE FOR UP TO 18 HOURS. INDIVIDUALS RESPOND UNIQUELY TO TREATMENT, YOU MAY SEE IMMEDIATE RESULTS AFTER THE FIRST TREATMENT OR DEPENDING ON THE SEVERITY OF YOUR CONDITION YOU MAY REQUIRE SEVERAL TREATMENTS BEFORE YOU BEGIN TO FEEL RESULTS.

INCREASED SORENESS MAY OCCUR AFTER YOUR FIRST LASER SESSION. THIS IS A NORMAL HEALING PHENOMENON KNOWN AS RETRACING. MILD BRUISING MAY OCCUR FROM THE SOFT TISSUE MANUAL THERAPY ELEMENT OF YOUR TREATMENT PROGRAM.

DO YOU HAVE A PACEMAKER OR ANY OTHER IMPLANTED DEVICES?	YES	NO
ARE YOU PREGNANT?	YES	NO
DO YOU HAVE CANCER?	YES	NO
ARE YOU TAKING MEDICATIONS THAT INCREASE YOUR SENSITIVITY TO LIGHT?	YES	NO
HAVE YOU HAD A STEROID INJECTION IN THE LAST 7 DAYS?	YES	NO

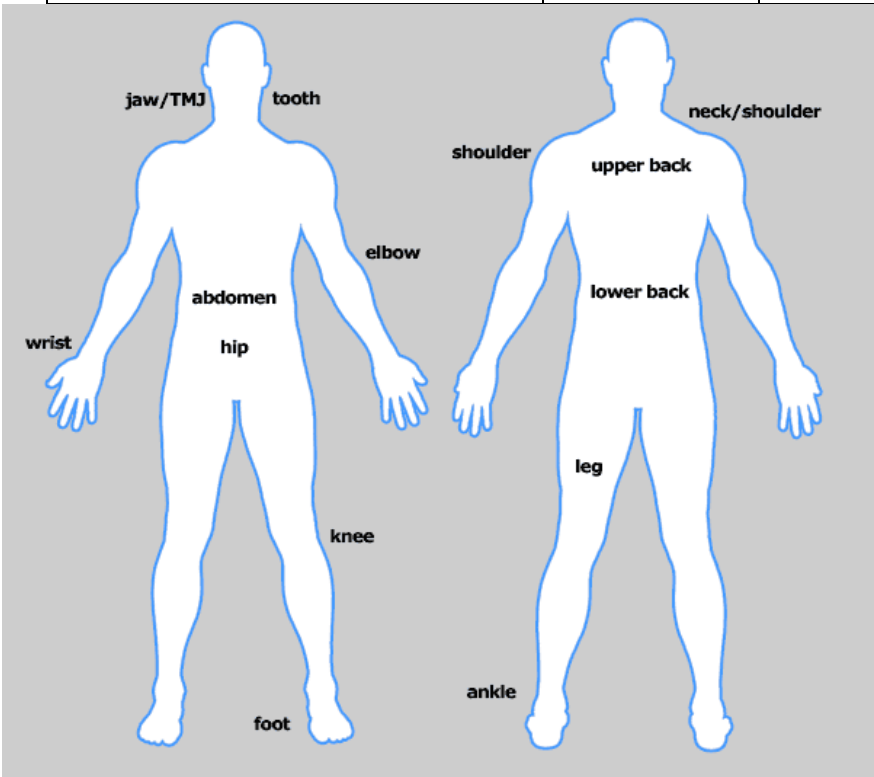
**\*\*\*BY SIGNING THIS CONSENT, I UNDERSTAND AND CONSENT TO TREATMENT. I UNDERSTAND THAT FAILING TO COMPLETE ANY PART OF MY TREATMENT PROGRAM WILL REDUCE MY CHANCES OF SUCCESS.**

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING (PRESCRIBED, VITAMINS, MINERALS, AND SUPPLEMENTS):

MEDICATION	DOSAGE	FREQUENCY TAKEN	ROUTE (ORAL, NASAL, ETC)
<b>Circle your area(s) of pain:</b>			



Please rank your pain level from 0-10  
(0 = no pain 10= worst pain imaginable)

\_\_\_\_ at worst in past week

\_\_\_\_ at best

\_\_\_\_ right now

I describe my pain as (circle all applicable):

Sharp      Shooting      Stabbing

Constant      Dull      Achy

Burning      Numb      Tingling

Other: \_\_\_\_\_

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE READ IT CAREFULLY.**

**TOTAL BODY THERAPY AND WELLNESS'S LEGAL DUTY**

TOTAL BODY THERAPY AND WELLNESS IS REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION, PROVIDE THIS NOTICE ABOUT OUR INFORMATION PRACTICES AND FOLLOW THE INFORMATION PRACTICES THAT ARE DESCRIBED HEREIN.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

TOTAL BODY THERAPY AND WELLNESS USES YOUR PERSONAL HEALTH INFORMATION PRIMARILY FOR TREATMENT, OBTAINING PAYMENT FOR TREATMENT, CONDUCTING INTERNAL ADMINISTRATIVE AND EVALUATING THE QUALITY OF CARE THAT WE PROVIDE. SOME EXAMPLES OF USES OF YOUR PERSONAL HEALTH INFORMATION MAY INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING: (1) CONTACTING YOU BY TELEPHONE/MAIL/EMAIL AND LEAVING A MESSAGE IF NECESSARY TO PROVIDE OR OBTAIN INFORMATION REGARDING APPOINTMENTS, YOUR TREATMENT, YOUR PATIENT ACCOUNT, TREATMENT ALTERNATIVES OR OTHER HEALTH RELATED BENEFITS AND SERVICES THAT WE OFFER, AND/OR COMPANY NEWS; (2) OBTAINING INFORMATION FROM YOUR REFERRAL SOURCE IN ORDER TO SCHEDULE AN APPOINTMENT AND TO VERIFY/AUTHORIZE INSURANCE BENEFITS; (3) ANNOUNCING YOUR ARRIVAL TO THE THERAPIST IN AN AREA WHERE OTHERS MAY HEAR THE INFORMATION; (4) CALLING OUT YOUR NAME IN THE WAITING AREA; (5) TREATING YOU IN AN OPEN AREA WHERE CONVERSATIONS BETWEEN YOU AND YOUR THERAPIST MAY BE OVERHEARD BY OTHER PATIENTS AND STAFF; (6) SHARING INFORMATION AS NEEDED WITH OTHER HEALTH CARE PROVIDERS INVOLVED IN YOUR CARE; (7) PERFORMING QUALITY ASSURANCE TASKS SUCH AS CHART REVIEW AND OUTCOME ANALYSIS; (8) FORWARDING INFORMATION TO YOUR INSURANCE CARRIER IN ORDER TO RECEIVE PAYMENT ON CLAIMS (AFTER OBTAINING YOUR MEDICAL RECORDS RELEASE AND INSURANCE ASSIGNMENT), AND/OR (9) SHARING INFORMATION TO INSURERS AND OTHER ENTITIES INVOLVED IN YOUR WORKERS' COMPENSATION CASE AS AUTHORIZED BY LAW.

TOTAL BODY THERAPY AND WELLNESS MAY ALSO USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION WITHOUT PRIOR AUTHORIZATION FOR PUBLIC HEALTH PURPOSES, FOR AUDITING PURPOSES, FOR RESEARCH STUDIES AND FOR EMERGENCIES. WE ALSO PROVIDE INFORMATION WHEN REQUIRED BY LAW.

IN ANY OTHER SITUATION, TOTAL BODY THERAPY & WELLNESS'S POLICY IS TO OBTAIN YOUR WRITTEN AUTHORIZATION BEFORE DISCLOSING YOUR PERSONAL HEALTH INFORMATION. IF YOU PROVIDE US WITH A WRITTEN AUTHORIZATION TO RELEASE INFORMATION FOR ANY REASON, YOU MAY LATER REVOKE THAT AUTHORIZATION TO STOP FUTURE DISCLOSURES AT ANY TIME.

**PATIENT'S INDIVIDUAL RIGHTS**

YOU HAVE THE RIGHT TO REVIEW OR OBTAIN A COPY OF YOUR PERSONAL HEALTH INFORMATION AT ANY TIME. YOU HAVE THE RIGHT TO REQUEST THAT WE CORRECT ANY INACCURATE OR INCOMPLETE INFORMATION IN YOUR RECORDS. YOU ALSO HAVE THE RIGHT TO REQUEST A LIST OF INSTANCES WHERE WE HAVE DISCLOSED YOUR PERSONAL HEALTH INFORMATION FOR REASONS OTHER THAN TREATMENT, PAYMENT OR OTHER RELATED ADMINISTRATIVE PURPOSES.

YOU MAY ALSO REQUEST IN WRITING THAT WE NOT USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT OR ADMINISTRATIVE PURPOSES EXCEPT WHEN SPECIFICALLY AUTHORIZED BY YOU, WHEN REQUIRED BY LAW OR IN AN EMERGENCY CIRCUMSTANCE. TOTAL BODY THERAPY & WELLNESS WILL CONSIDER ALL SUCH REQUESTS ON A CASE-BY-CASE BASIS, BUT THE PRACTICE IS NOT LEGALLY REQUIRED TO ACCEPT THEM.

**CONCERNS AND COMPLAINTS**

IF YOU ARE CONCERNED THAT TOTAL BODY THERAPY & WELLNESS MAY HAVE VIOLATED YOUR PRIVACY RIGHTS OR IF YOU DISAGREE WITH ANY DECISION WE HAVE MADE REGARDING ACCESS OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION, PLEASE CONTACT OUR PRIVACY/SECURITY OFFICE AT THE ADDRESS BELOW. YOU MAY ALSO SEND A WRITTEN COMPLAINT TO THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES. TOTAL BODY THERAPY & WELLNESS WILL NOT TOLERATE ANY RETALIATORY ACTS AGAINST ANYONE WHO FILES A COMPLAINT. FOR FURTHER INFORMATION ON TOTAL BODY THERAPY & WELLNESS HEALTH INFORMATION PRACTICES, OR IF YOU HAVE A COMPLAINT, CONTACT THE FOLLOWING PERSON: SARA MORRISON, TOTAL BODY THERAPY & WELLNESS, 2 THE SQUARE AT LILLINGTON, LILLINGTON, NC 27546, PHONE: (910) 893-2850, FAX: (910) 984-1515.

**PLEASE READ AND INITIAL INDICATING THAT YOU ARE AWARE OF AND WILL ADHERE TO THE FOLLOWING POLICIES:**

\_\_\_\_\_ THE INFORMATION ON THE PATIENT INTAKE FORM IS CORRECT TO THE BEST OF YOUR KNOWLEDGE. YOU AGREE THAT YOU WILL NOTIFY TBTW IMMEDIATELY OF ANY INSURANCE CHANGES OR CHANGES IN PERSONAL INFORMATION. FAILURE OF WHICH MAY RESULT IN DENIAL OF COVERAGE, THE FEES FOR WHICH YOU WILL BE RESPONSIBLE.

\_\_\_\_\_ CHARGES FOR SERVICE ARE DUE AT THE TIME OF SERVICE. PLEASE CHECK IN AND OUT TO MAKE SURE ALL CHARGES HAVE BEEN PAID BEFORE LEAVING CLINIC.

\_\_\_\_\_ CANCELLATIONS OR NOT SHOWING FOR AN APPOINTMENT: AS A COURTESY TO OUR PATIENTS WE REQUIRE THAT YOU CANCEL ANY APPOINTMENTS THAT YOU CANNOT MAKE WITH NO LESS THAN A DAY'S NOTICE. TO BETTER HELP OUR PATIENTS, CANCELATIONS MUST BE DONE DURING BUSINESS HOURS, MONDAY TO THURSDAY 7:30 AM - 5:00PM. TWO CONSECUTIVE NO SHOW, WITH NO PATIENT COMMUNICATION WILL RESULT IN YOUR FUTURE APPOINTMENTS BEING REMOVED FROM OUR SCHEDULE AND YOU WILL BE CONSIDERED DAY BY DAY. THREE CANCELLATIONS MADE LESS THAN A DAY'S NOTICE, WILL RESULT IN YOUR APPOINTMENTS BEING REMOVED FROM OUR SCHEDULE AND WILL BE CONSIDERED DAY BY DAY. **IF YOU FAIL TO SHOW FOR AN APPOINTMENT WITH OUT A DAY'S NOTICE, YOU WILL BE CHARGED A \$50.00 FEE. A MISSED DIAGNOSTIC APPOINTMENT IS A \$150.00. A MISSED DRY NEEDLE APPOINTMENT IS \$40.00.** IF YOU ARE RUNNING LATE, PLEASE CALL US IMMEDIATELY, IF YOU ARRIVE 15 MINUTE PAST YOUR SCHEDULE APPOINTMENT, THE APPOINTMENT WILL BE CANCELLED AND YOU WILL CHARGED A MISSED APPOINTMENT FEE.

\_\_\_\_\_ I UNDERSTAND TBTW WILL NOT PERMIT ANY REFUNDS OR EXCHAGES FOR DME ITEMS, DEEP TISSUE LASER PACKAGES, OR DRY NEEDLING PACKAGES PURCHASED.

\_\_\_\_\_ I UNDERSTAND THAT ANY ACCURED BALANCES ON MY ACCOUNT WHILE A PATIENT AT TBTW MUST BE PAID IN FULL TO RECEIVE CREDIT.

\_\_\_\_\_ APPOINTMENT REMINDERS: WE SEND APPOINTMENT REMINDERS VIA TEXT, PHONE, OR EMAIL. PLEASE LET US KNOW WHICH METHOD OF NOTIFICATION IS BEST FOR YOU.

\_\_\_\_\_ I UNDERSTAND AND AGREE THAT INSURANCE CLAIM FORMS WILL BE SUBMITTED TO MY INSURANCE COMPANY AS A MATTER OF CONVENIENCE ONLY, AND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF MY EXISTING MEDICAL COVERAGE. I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO TBTW FOR SERVICES RENDERED. IN THE EVENT THAT MY INSURANCE COMPAY FORWARDS PAYMENT DIRECTLY TO ME INSTEAD OF TBTW, I WILL IMMEDIATELY DELIVER SAID PAYMENT TO TBTW. AUTHORIZATION TO RELEASE INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO VERIFY BENEFITS/OBTAIN PAYMENT OR COMPLETE TREATMENT.

\_\_\_\_\_ I UNDERSTAND AND AGREE THAT I AM WHOLLY RESPONSIBLE AND LIABLE FOR PAYMENT AND ALL CHARGES ASSESSED FOR PROFESSIONAL SERVICES RENDERED AND WILL PAY ANY SUM DUE WHEN REQUESTED. I UNDERSTAND AND AGREE THAT IF NECESSARY, TO COMMENCE LEGAL ACTIONS FOR THE COLLECTION OF ANY OUTSTANDING CHARGES ON MY ACCOUNT, I WILL BE RESPONSIBLE FOR ANY COSTS AND/OR COURT FEES, IN ADDITION TO OUTSTANDING BALANCE.

\_\_\_\_\_ ASSIGNMENT OF BENEFITS/PROCEEDS: I HEREBY INSTRUCT AND DIRECT ALL PAYERS RESPONSIBILITY FOR MAKING PAYMENTS TOWARDS THE TREATMENT OF MY INJURIES TO PAY TBTW, 2 THE SQUARE AT LILLINGTON, LILLINGTON, NC 27546 FOR THE PROFESSIONAL OR MEDICAL BENEFITS/PROCEEDS ALLOWABLE, AND OTHERWISE PAYABLE TO ME AS PAYMENT TOWARD TOTAL CHARGES FOR THE PROFESSIONAL SERVES RENDERED. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS/PROCEEDS UNDER ANY APPLICABLE POLICIES/AGREEMENTS. I FURTHER INTEND FOR THIS ASSIGNMENT TO CREAT A SECURED INTEREST UNDER THE APPLICABLE UNIFORM COMMERCIAL CODE.

\_\_\_\_\_ CONSENT TO EVALUATION AND TREATMENT: I DO HEREBY CONSENT TO THE EVALUATION AND TREATMENT OF TBTW. I UNDERSTAND IT IS MY RIGHT TO ACCEPT OR REFUSE ANY TREATMENT OFFERED TO ME. I ACKNOWLEDGE AND UNDERSTAND THAT NO GUARANTEE HAS BEEN MADE TO ME AS TO THE RESULTS THAT MAY BE OBTAINED FROM SUCH TREATMENT. YOU WILL SEE MORE THAN ONE THERAPIST DURING YOUR TIME HERE AT TBTW.

\_\_\_\_\_ **WE OPERATE AS A TEAM TO ENSURE THE HIGHEST QUALITY OF CARE. ALL THERAPISTS HAVE DIFFERENT EXPERIENCES AND SPECIALITIES, WHICH ALL CONTRIBUTE TO HELPING TO ATTAIN OPTIMAL RESULTS FOR OUR PATIENTS. AS SUCH, OUR TEAM MEMBERS WILL WORK COLLABORATIVELY TO BEST ADDRESS YOUR NEEDS.**

\_\_\_\_\_ I ACKNOWLEDGE THAT I WILL REQUIRE A FORMAL DISCHARGE/GRADUATION APPOINTMENT IN ORDER TO END MY PHYSICAL THERAPY COURSE AT TBTW.

\_\_\_\_\_ I UNDERSTAND AND ACKNOWLEDGE THE RECEIPT OF TBTW'S NOTICE OF PATIENT INFORMATION PRACTICES AND PRIVACY POLICY.

\_\_\_\_\_ TBTW WANTS TO HELP EVERYONE GET BACK TO NORMAL WITHOUT MEDICATION, SHOTS OR SURGERY! IF YOU HAVE SUCCESS, PLEASE REFER A FRIEND TO HELP THEM ACHIEVE THEIR GOALS! BRING A FRIEND TO A WORKSHOP FOR A FREE DEEP TISSUE LASER CONSULTATION.

\_\_\_\_\_ **OPTIONAL:** I CONSENT FOR MY PICTURE AND ANY VIDEOS TAKEN OF ME, WITH MY KNOWLEDGE, TO BE USED FOR PROMOTIONAL PURPOSES.

\_\_\_\_\_  
SIGNATURE (PATIENT AND/OR PARENT OR LEGAL GUARDIAN)

\_\_\_\_\_  
DATE