Consent for Therapy

I hereby consent for authorized personnel from Healing The Generations to perform all necessary procedures and treatment as prescribed by my physician.

Photo Release

I consent to taking and publishing of still or motion pictures of the patient during treatment for the use of advertisement or public education. I further agree that the information from the patient’s medical record may be disclosed for educational and/or research purposes.

Yes, I do consent to taking and publishing of still or motion pictures during treatment.

By signing below, I acknowledge that I have read and understand the contents of this form and I am competent to execute it or if executed on behalf of another, I am authorized to execute it on behalf of that person.

Yes, I do allow text messages and/or emails for promotional information and appointment reminders

Cell phone for text messages: 

Email for appointment reminders: 

Signature of patient or person authorized to consent Date

Relationship to patient