Healing The Generations, Inc.
"A Strictly Hands-On Therapy Services Provider for Children and Adults"

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.

_____ initials **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.

_____ initials 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 _____

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