L2 PT and Bodyworks

Patient Name:			**Primary Care Doctor:**	
Address:			Facility Name:	
			Address:	
Home phone:				
Cell phone:			Phone:	
Email:				
DOB:	M or F			
Diagnoses:				

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone number:	Work Phone and/or Cell Phone Number:

The above information is true to the best of my knowledge. I understand that I am consenting to treatment and will pay with cash or check at the time of my visit. I may discontinue treatment at any time and will speak to Louise Lynch directly by phone if I have any concerns about the treatment I am recieving.

______________________________ ______________________

Patient Signature Date

Created 4.2.20