328 10 Street N.W.
Calgary, AB T2N 1V8
(403) 237-6866
www.effectivehealth.ca

BOWEN THERAPY

Name: _____
(First) (Initial) (Last)

Address:_____
(Street) (City) ([Postal Code)

Home Phone:_____Work Phone:_____ Cell Phone:_____

Employer:_____ Occupation:_____

Email Address:_____

Date of Birth:_____ Age:_____ Male ☐ Female ☐
(Month/Day/Year)

How did you find out about our clinic? _____

If referred please give name of referee (so we can thank them):_____

Would you like to receive the clinic e-mail newsletter? Yes ☐ No ☐

Emergency Contact:

Name:_____ Relationship:_____ Phone:_____

Family Doctor: _____
(Given) (Surname)

Treating Doctor: _____ PHONE:_____
(Given) (Surname)

Consent for Liability for Cost

I hereby acknowledge and understand my liability of any costs incurred by myself at this office.

Consent for Treatment

I hereby authorize and grant permission to Tasleem Kassam to treat me using Bowen Therapy. I understand the procedure and associated effects.

I acknowledge that this form has been explained to me and that I fully understand the contents of this form and its implications.

Patient's Name: _____

Patient's Signature: X _____ **Date:** _____
(If you are under 18 years of age, a parent or guardian must sign this form)

OR

Guardian's Signature: X _____ **Date:** _____