Somatic Science LLC **Federico G. Anguiano SEP CQM**

Client Name: ____Home Phone: __________________

Home Address: ___________________________City: ________________________State: ____________

Zip: _____________E-mail address: ______________________ Cell Phone:__________________

Date of Birth: _____/_____/_____, Age___________ Relationship to you: ____________________

In Case of Emergency Notify: ___________________________

Phone:_______________________Address: ____

Who referred you/how did you hear about us? _________________________ Phone: ________________

1. ***I understand that Somatic Science® includes methods and processes that are supported in their use by scientific evidence, however their effectiveness for me in achieving my goals cannot be guaranteed in advance.***
2. ***I understand that no guarantees concerning the above therapies or their efficacy has been given to me, and that I volunteer to receive this treatment solely because of my own personally held belief that the aforementioned therapies may be effective in my particular care.***

I hereby certify that I have read and fully understand the entire contents of this form, and sign it freely and voluntarily without inducement.

Signature: ___________ Date: _____ Parent's/guardian's signature if under 18:

Signature: ____ Date: ____________________________

Parent's/guardian's name & signature if client is under 18 years of age:________________________________

Please help us protect your privacy by checking the appropriate boxes.

☐ Do ☐ Do not leave messages on my ***HOME*** answering machine.
☐ Do ☐ Do not leave messages with any other person.

☐ Do ☐ Do not leave messages on my ***WORK*** voice mail.
☐ Do ☐ Do not leave messages with co-workers.

☐ Do ☐ Do not leave messages on my ***CELL PHONE*** voice mail.
☐ Do ☐ Do not leave messages with any other person answering cell phone.