MATTHEW
BEREAN ROLFING®
CERTIFIED ROLFER™

Client Information

TODAY'S DATE

NAME DATE OF BIRTH

STREET ADDRESS CITY STATE ZIP

MAILING ADDRESS (IF DIFFERENT FROM STREET ADDRESS) CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE

OCCUPATION EMPLOYER

WORK ADDRESS

EMAIL ADDRESS

WAIVER

I fully understand the purpose of Rolfing is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. This is done through direct manipulation and education so that greater economy of body-movement is achieved. I understand Rolfing is not involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed. The Rolfer does not treat, prescribe or diagnose an illness, disease, or any other physical or mental disorder of the person. Nothing said or done by a Rolfer should be misconstrued to be such. I understand it is necessary for the Rolfer to touch my body in order to assist me in establishing balance and alignment of my body.

I give Matthew Berean my permission and consent to do all those things necessary in helping me establish balance and alignment, including but not limited to touching my body. I give Matthew Berean full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein.

Furthermore, I understand that any relief of physical or emotional symptoms is coincidental in the organization of the total human being and is not the goal of Rolfing.

IN CASE OF CANCELLATION I agree to give 24 hours advance notice of scheduled session, or to assume responsibly for payment of the full fee.

By signing below, I acknowledge that I have read and understood all parts of this waiver, that I have had the opportunity to ask any questions regarding the services provided.

CLIENT SIGNATURE (PARENT OR GUARDIAN IF CLIENT IS UNDER 18 YEARS OF AGE) DATE

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