FINANCIAL AGREEMENT and WAIVER OF LIABILITY

I understand that I am fully responsible for payment of services with cash, check or credit card and agree to pay Mindy Cohen, PT, CST at the time that the professional services are rendered. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved with this case.

I understand that if I am unable to keep an appointment, I must provide 24 hours notice of cancellation. If sufficient notice is not received, I will be billed the cost of the session for the missed appointment.

I certify that all information regarding medical conditions and injuries has been provided on the "client information" sheet is true and correct to the best of my knowledge. I will notify Mindy Cohen PT, CST if my health status or the stated information changes.

I hereby request and consent to treatment from Mindy L. Cohen, PT. I understand that my treatment may include the provision of varied therapies including, but not limited to Physical Therapy, CranioSacral Therapy, SomatoEmotional Release, Myofascial Release, Lymphatic Drainage, Muscle Energy techniques and Resonant Kinesiology. I realize that the particular therapeutic outcomes of these treatments, individually and jointly, can not be predicted with certainty and no guarantee is made regarding any particular result or outcome. I understand that craniosacral therapy is provided for the basic purpose of relaxation and relief of muscular tension and to release restrictions in the nervous system. I further understand that craniosacral therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. If I experience pain or discomfort during the session, I will immediately inform Mindy Cohen PT, CST so that pressure/strokes can be adjusted to my level of comfort. I will not hold Mindy Cohen PT, CST responsible for any pain or discomfort I experience during or after the session. I understand that Mindy Cohen, PT, CST is not qualified to treat mental illness. By signing this release, I hereby waive and release Mindy Cohen PT, CST from any and all liability, past, present, and future relating to any of the above therapies performed.

By signing this agreement, I acknowledge the contagious nature of COVID-19, and voluntarily assume the risk that I may be exposed to or infected by COVID-19 while attending a bodywork session with Mindy Cohen, PT, CST and that such exposure or infection may result in personal injury, illness, permanent disability, or death. I understand that the risk of becoming exposed to or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others in the building. I understand that Mindy Cohen, PT, CST has put in place protocols and guidelines for cleaning and safety and agree to uphold that criteria. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, or death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with participating in these sessions. On my behalf, I hereby release, covenant not to sue, discharge and hold harmless Mindy Cohen PT, CST, the office, visitors to the office, other office workers or any contractors, out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Mindy Cohen, PT, CST, her office and representatives, whether a COVID-19 infection occurs before, during, or after my time at each session.

SIGNATURE:_____DATE:_____

PRINT NAME: _____

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IF THE CLIENT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

SIGNATURE OF LEGAL PARENT/GUARDIAN:_____ DATE:_____

PRINT NAME OF LEGAL PARENT/GUARDIAN:_____