REGISTRATION FORM

Lifeshots
It's all about well-being

*BASIC INFORMATION

First Name ____ Middle Name ____ Last Name ____

Birth Date ____ Gender ☐ Male ☐ Female Age ____

Resi. Address:

Building Name ____ Flat No ____ Street ____

City ____ State ____ Pin-code ____

Contact Details:

E-mail ID ____ Mobile No ____ Emergency Contact ____

*HOW DID YOU HEAR ABOUT LIFESHOTS ?

Walk-in ☐ Health practitioner ☐ Google ☐ Email ☐ Website ☐ Event ☐

Social Media ☐ Voucher ☐ Referred By Name Contact

Others ____

*DO YOU HAVE ANY OF FOLLOWING HEALTH CONDITIONS ?

☐ Cardiac	☐ Migraine	☐ Neuro	☐ Obeisity
☐ Diabetes	☐ High BP	☐ Balancing	☐ Underweight
☐ Allergies	☐ Injury	☐ Cancer	☐ Depression
☐ Insomnia	☐ Dementia	☐ Rheumatoid Arthritis	☐ Anxiety
☐ Body Pain	☐ Asthama	☐ Pregnancy	☐ Pace Makers Cholestrol
☐ Seizures	☐ Anxiety	☐ Fibromyalgia	☐ Metal implants
☐ Others			

*ARE YOU UNDER ANY MEDICATION ? PLEASE SPECIFY

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Disclaimer: To register for the Lifeshots services, its mandatory to provide above information relate to your current and previous health condition and complete the registration process. Please ensure you fill all the fields marked with an asterisk *. All information is held in strictest confidence. No information is disclosed or shared without your written consent. Lifeshots Healthcare Solution LLP reserves the right, at its discretion, to change, modify, add, or amend its terms at any time. Please check these terms periodically for changes.

CENTRE POLICIES

- Customer services and chart information are confidential. Written authorization is required from you to release any information.
- Please turn off your mobile phone for optimal benefit & better results
- Your scheduled session is set aside for you. We do not double book appointments
- Please provide at least 24 hour cancellation notice to avoid being charged a cancellation fee 80%. Less than 24 hours notice will incur a cancellation fee of 100% of the scheduled fee
- You will have a consultation with your practitioner to discuss your session

CUSTOMER AGREEMENT

- I understand that at any time I feel pain or discomfort during the session, I will immediately inform my practitioner. I have stated my pertinent medical conditions, and will update the practitioner of any changes in my health status.
- I understand that my failure to do so may pose a threat to my health and physical well being and I hold harmless Lifeshots Centre and my practitioner from any liability whatsoever arising from failure on my part.
- I hereby agree and consent to the performance of treatment, therapies & procedures. I understand their contraindications
- I am relying on the practitioner to exercise judgment and caution during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify, or change the treatment plan.
- I will inform my practitioners immediately of any discomfort with this arrangement and steps will be taken to modify my treatment. By voluntarily signing below, I hereby certify that I have read this entire form, have been told about the details & benefits of therapies and treatment along with other procedures, and have had an opportunity to ask questions. I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition. I have read this form, understand the information it contains, and give my consent to treatment.

Signature:

Date: _____