Therapist: __________________

The Day Spa at Goldsboro Spine Center

605 N Spence Ave Goldsboro, NC 27534

TIME:	
SESSION TYPE:	
COST:	
TIP:	
TOTAL:	

Patient Name: ____________________________

Date: ____________________________

Pain level TODAY on scale of 0 to 10?

(zero = no pain, 10 = extreme pain)

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Goal for today's session?

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____

I , (*print name)*___________________________, authorize The Day Spa at Goldsboro Spine Center to treat my condition or that of the patient name above. I am responsible to The Day Spa at Goldsboro Spine Center for charges not covered by insurance. I authorize release of my medical records to my insurance company and if an industrial injury to my employer and state industrial commission.

Patient Signature ____

The section below is for your therapist.

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