



craniosacral institute of michigan, LLC

I have read and understand the CranioSacral Institute of Michigan's *Therapy Commitment/ Attendance Policy* and I agree to be bound by its terms.

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Signature of Patient Name (or responsible party, if minor)

Date

I have read and understand the CranioSacral Institute of Michigan's *Financial Policy* and I agree to be bound by its terms. I also understand and agree that such terms may be amended by CranioSacral Institute from time to time.

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Signature of Patient Name (or responsible party, if minor)

Date

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Please Print the name of the patient

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