Rolfing by Robert Toporek.

REGISTRATION FORM

FIRST NAME_____LAST NAME_____

E-MAIL_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE (____) _____WORK PHONE (____) _____

DATE OF BIRTH_____HEIGHT_____WEIGHT_____

OCCUPATION_____TITLE_____

SINGLE_____LIVING TOGETHER_____MARRIED_____DIVORCED_____

INTITAL CONSULTATION_____PHASE 1____PHASE 2____PHASE 3____

INITIAL COST $_____AMOUNT PAID $_____BALANCE DUE $_____

I understand Rolfing by Robert Toporek is not involved with treatment or diagnosis of disease. It does not substitute for medical or psychological treatment when such attention is needed, wanted, or required. The Rolfing by Robert Toporek PROGRAM does not treat, prescribe, or diagnose an illness, or any other physical or emotional disorder. Nothing said or done by Rolfing by Robert Toporek should be misconstrued as such.

I also understand the purpose of the Rolfing by Robert Toporek **is to free my body and life from patterns of tension that were either inherited or acquired through life's experiences. This will help transform the impact my posture has on my overall well being, aches and pains, behavior, development, productivity, and self-expression. These results are achieved through education, awareness, and through direct highly specialized touch. I understand and agree with the premise of connective tissue being chronically shortened or stuck together and the concept of inherited postural positions. I agree and understand that the focus of the** Rolfing by Robert Toporek **is to have my posture/body better balanced, aligned, and integrated. Also, I understand that during my consultations we will be exploring how each part of my body relates to corresponding areas and issues of life and am under no obligation to accept the views or positions of my practitioner. I give my Robert Toporek my Advanced Certified Rolf practitioner full privilege and license to work with me in a way that achieves the goals of each session. I also acknowledge that I am fully responsible for my participation in this program.**

My signature acknowledges that I have read, understand, and will comply with the above policy.

DATE_____SIGNATURE_____

Rolfing by Robert Toporek
DRAW A PICTURE FORM

NAME_____

DATE_____

ON A SCALE OF 1 TO 10, 10 being the best

Rate your overall experience of your posture/body

(Circle one) 1 2 3 4 5 6 7 8 9 10

Explain_____

How do you view your posture?_____

How do you think others view your posture? _____

What do you like most about your posture?_____

What do you like least about your posture?_____

How has your experience of your posture affect your life? _____

What new posture and or postures are you committed to? _____

Rolfing by Robert Toporek
REQUESTS/PROMISES FORM

Name _____Date_____

Phase 1____ 2____ 3____

As you participate in the Rolfing by Robert Toporek program remarkable results are possible.

*** TRANSFORM your posture in your body life.**
*** RELIEVE aches and pains you have been accepting as "normal".**
*** GREATLY reduce tension in your body.**
*** SIGNIFICANTLY increase your overall well-being.**
*** EXPERIENCE a greater freedom of self-expression.**
*** LET GO OF positions and attitudes that no longer serve you.**

The process of completing this form is an integral part of your Rolfing by Robert Toporek **The more specific you are at making requests and promises, the better we can serve you and the better results you can expect. State specifically your requests regarding your participation. Make promises for how you will use these sessions to influence areas in your life and the lives of those around you (i.e., physical, emotional, and mental well being, relationships, family, career, organizations, and other commitments).**

REQUESTS:

_____

_____

_____

_____

PROMISES:

_____

_____

_____

_____

CANCELLATION POLICY

From time to time emergencies occur and either you or we cannot keep your appointment. Sometimes this cannot be helped so we try to remain flexible. However, this is not simply our service it is our business, job, and therefore means of income. When someone does not come at the last minute we lose money. Filling an appointment at the last minute is nearly impossible. If you do have to cancel please give us at least 24 hours notice unless you are having a real emergency. Otherwise we request you contribute to the cost of that session to the Philadelphia Children's Project. By signing this notice you agree to abide by this policy.

DATE_____SIGNATURE_____

Rolfing by Robert Toporek
Video/Photo RELEASE FORM

To document and express the benefits of Rolfing by Robert Toporek we videotape and \or photograph each event.

Only with your written permission will any of this material be used for public presentation. However with your permission we can share the benefits of this program with many other people with similar concerns and commitments.

Signing this release is not a requirement ONLY a request. We use these videos and pictures in documentary slide shows, books, pamphlets, video documentaries and any other way that we deem appropriate. **By signing this document you are permitting us to use your documentation.**

I give Rolfing by Robert Toporek the absolute rights to copyright and/or publish, or use any video or photographic pictures of me, or in any video or photographs of which I may be included in whole or part, or composite or character or form, with my own or a fictitious name or reproduction of it in color of otherwise made through any media for educational or any other lawful purpose at all.

Further, I waive my right to inspect and/or approve the finished product or the copy that may be used in connection therein, or the use to which they may be applied.

I discharge, and agree to save the above named parties from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise that may occur or be produced in the taking of said videotape/pictures or in the process tending toward the completion of the finished product.

Signature _____ Date _____

Please print clearly
Name _____

Address _____

City _____ State _____ Zip_____

Phone Home _____ Phone Mobile _____

Email _____