Susan R. Tieche OTR/L

Jennifer Bilyew, M.S., CCC-SLP

Cranial-Sacral Background Information

Name: _____

Address:_____
_____

Ph number: H: _____ Cell: _____

Email Address: _____

Please describe your **primary reasons** for seeking out **cranial-sacral therapy:**

Please list all injuries, surgeries, and traumatic events along with the year or age of each occurrence:

If applicable, please describe any pregnancies and birth histories. If you have details about your own birth and early development, please describe.

Susan Tieche, LLC and Jennifer Bilyew
Pediatric Occupational Therapist and Speech and Language Pathologist
Office: (301) 933-7880
Fax: (301) 933-7911

Credit Card/ Debit Transaction Processing Authorization Form

☐ Yes, I would like you to automatically charge my credit card for services rendered each month.
☐ Yes, I would like to have my checking account debited for services rendered each month.

	Card Type	Number	Exp. Date	3 digit code on back of card
☐	Visa	_____	_____	_____

Billing Address and Name on the card:

_____
_____
_____

		Number	Exp. Date	3-digit code on back of card
☐	MasterCard	_____	_____	_____

Billing address and Name on the card:

_____
_____
_____

By signing this Agreement, and marking the box noted above, the undersigned does hereby agree as follows: (i) the undersigned does hereby authorize and agree that Susan Tieche, LLC and/or its duly authorized agent (the "Company") and Jennifer Bilyew have the right from time to time to charge to the above identified credit card and/or debit the account identified above any and all amounts that are owed to the Company and/or its consultants, (ii) the undersigned agrees that its signature on this Agreement shall be deemed its signature on any sales charge receipt or other form and if any merchant services, credit card company, or bank requests to view the undersigned signature on a sales charge receipt or other form, the Company may provide such company with a copy of this Agreement and such shall be deemed conclusive proof that the undersigned approved and authorized the charge and/or debit at issue, and the undersigned does hereby waive any right to dispute its authorization to such charge based on an invalid or non-existent signature. The undersigned understands and agrees that the above payment option and charges or debits will continue each month for services rendered by the Company and/or its consultants until such time as the undersigned has provided written notice to the Company to stop such automatic charges and/or debits. The undersigned shall be fully responsible for ensuring that it has sufficient credit and/or funds to cover the charges or debits, and shall indemnify the Company against all costs incurred as a result of any declined charge or debit.

AGREED AND ACCEPTED:
Cardholders Signature:_____ Date:_____
Print Name:_____
*All credit cards will be processed on the first day of each month.
**All Debits will be processed on the first day of each month.
I,_____ authorize Susan Tieche, LLC and Associates and Jennifer Bilyew to electronically mail paid invoices in PDF file to the following email address_____.

10605 Concord Street
Suite 102
Kensington, MD 20895

(301) 933-7880 FAX: (301) 933-7911

Acknowledgement and Assumption of Risk
Cranial-Sacral Therapy

I, _____ (print name) acknowledge and agree to have my child (or the child under my care), _____ (print child's name) receive cranial-sacral therapy from Susan Tieche, LLC, Susan R. Tieche OTR/L and/or Jennifer Bilyew, M.S., CCC-SLP under the foregoing at ITS: Developmental Therapy Services, INC. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Susan Tieche, LLC, Susan R. Tieche, Jennifer Bilyew, M.S., CCC-SLP, and ITS: Developmental Therapy Services, Inc. harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belonging.

_____ _____
Signature Date
Print Name:_____