Korman Relief & Wellness Center

STAR PATIENT - Testimonial

Which of the following services apply to your care?

- ☐ *Nutrition Services with Dr. Korman*
- ☐ *Dr. Korman's GEARED2bewell Programs*
- ☐ *Personal Health Guide (on smartphone)*
- ☐ *Laser Therapy*
- ☐ *Neuropathy Therapy*
- ☐ *Other Therapies*
- ☐ *Chiropractic Services*
- ☐ *Massage Therapy / Spa Services*

Describe your reason for seeking care.____

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How has this issue been adversely affecting your life and for how long?

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How has your issue improved or relief been provided by your visit(s) to our clinic?

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1) May we use this testimony to display in our office and/or in marketing materials so others can know the benefits of our health care services? Yes / No

2) Would you be willing to allow us to video tape your testimonial to be used on our website and/or media marketing?
Yes / No

Patient Signature ____ Date ____________

Thank you! Please ask us for a referral card, providing a significant discount to your referral for their first visit to our practice! Our practice has been built largely on the referrals from our patients, and we appreciate you telling others about the care you received here, which allows us to extend our reach and help others in discomfort achieve optimized health in a non-invasive manner!