

# PRE/POST NATAL REGISTRATION FORM

Name\_\_\_\_\_

Phone:\_\_\_\_\_

Email Address\_\_\_\_\_

Is this the first time registering for this program:

Yes      No

Do we have your Physician's Approval?      Y      N

Health History questionnaire?      Y      N

Are you a member at LFHFC:      Y      N

## FEES:

10 pack	\$150
5 pack	\$90
Sneak peak demo	\$20

## Method of Payment

Cash

Check #: \_\_\_\_\_

House charge- Acct# \_\_\_\_\_

Visa/MC: \_\_\_\_\_

Exp. Date: \_\_\_\_\_

Signature\_\_\_\_\_ Date\_\_\_\_\_