

I have been a patient since, _____.

I allow my initials, or first name to be used with my testimonial. **YES** **NO**
(if YES, circle one) INITIALS ONLY FIRST NAME ONLY

Would you recommend friends and family to our practice? **YES** **NO**

Can we use an excerpt of your testimonial? **YES** **NO**
(what you really said, not paraphrased)

Are you including photograph(s)? **YES** **NO**
(ex. before and after photos or just a current picture if yourself)
PLEASE DO NOT INCLUDE OTHERS IN YOUR PHOTOGRAPH(S).

I, _____, understand that I have the right, at any time, to withdraw my testimonial, photographs, etc. by contacting our office on 443-490-1240. Please allow 1 week for such testimonials, photographs, etc. to be removed from media.

Please mail completed form to, we will ask that you email photos if you want them included:
Nancy Lum
700 Geipe Rd., Ste. 274
Catonsville, MD 21228

Patient Name: _____ Date: _____
(Patient name, please print clearly)

Patient Signature: _____
(Signature of patient)

Thank you for your interest in encouraging other patients to make the healthy lifestyle changes you have committed to. We greatly appreciate your time and wanting to share your experiences and journey with others!

Nancy Lum ☺