**CloudTMS Feedback Form**

Please describe the benefits you have experienced from TMS and any details about your overall experience at COMPANYNAME.

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By signing below you give COMPANYNAME permission to share your patient testimony with others. This information will be shared with the community either anonymously or with your first name. Thank you for your time and consideration!

Please place a check next to the identification option that you would prefer if your feedback is shared with the community:

❐  *-Anonymous*

❐ *-First Name*

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Name Signature Date

We understand that you have options when choosing a provider to entrust with your care. We appreciate that you have taken the time to share what sets COMPANYNAME apart from other providers. By providing feedback about our services to others you are helping to connect our community with affordable and high quality TMS services.

Thank you for trusting COMPANYNAME with your treatment!