Massage Therapy Waiver

I, _____, understand that the massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist, so the treatment can be adjusted.

I understand and agree to abide by the therapists polices and will not hold Alive and Well Corp or the therapist responsible for any personal injury or loss of property.

Printed Name: _____ Date:_____

Signature: _____

Emergency Contact: _____ Number: _____

Email:_____

MY MASSAGE REFFERALS

Receive an Extra 10 Minutes added on to your next Massage!

(Get 10 minutes per referral that has completed a massage at Alive and Well)

Name:

_____

Phone:

_____

Email:

_____

Name:

_____

Phone:

_____

Email:

_____

Name:

_____

Phone:

_____

Email:

_____

Name:

_____

Phone:

_____

Email:

_____

Service Agreement

Agreement I: Purchase of Service

I, the undersigned, agree to use the purchased services of Alive and Well within 60 days of the purchase date. If services are not rendered, per the undersigned, after the 60th day of purchase, I, the undersigned, will relinquish any claim for a refund, per this 60 day purchase of service term agreement.

Agreement II: Cancellation / Late

Alive and Well Corp. understands that unexpected events arise in the lives of our clients: E.g. transportation complications, illness, child care matters, etc.). In our desire to be effective and fair to all of our clients, and out of consideration for our therapist's time, we have adopted and require the following policies:

- In most cases, a 24-hour advance notice is required when canceling an individual appointment. This allows the opportunity for someone else to avail themselves of our services.
- If you are unable to give us the minimum 24-hours advance notice, and we are unable to fill your time slot, you will be charged in the amount of $25. At our discretion this charge will be either automatically deducted from the authorized payment medium, or paid in full prior to your next treatment.
    - *If an individual does not have a payment method on file and/or funds are not tendered to Alive and well within 30 days of the cancelation notice, a claim will be filed for collections.*
- If you arrive later than 15 minutes, without prior acknowledgement, from your scheduled session with a therapist, it will be the discretion of the therapist if you can be treated for services. Furthermore, if you are seen by the therapist, despite being late, the full allotted time may not be actualized if there is a client scheduled within a half hour after your initially scheduled session. after your set appointment.

By signing below I, the undersigned, acknowledge that I have fully read and understood this Purchase of Services agreement and agree with its contents.

_____ _____

(Print, First and Last Name) (Alive and Well Representative)

_____

(Please Sign)

Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ Yes ☐ No

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ Yes ☐ No

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ Yes ☐ No

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ Yes ☐ No

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer ☐ Fibromyalgia

☐ Stroke ☐ Headaches/Migraines

☐ Arthritis ☐ Heart Attack

☐ Diabetes ☐ Kidney Dysfunction

☐ Blood Clots ☐ Joint Replacement(s)

☐ Numbness ☐ High/Low Blood Pressure

☐ Neuropathy ☐ Sprains or Strains

Explain any conditions you have marked above: _____

_____

_____

Massage Information

Have you had a professional Massage before? ☐ Yes ☐ No

What type of Massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or Sensitivities? ☐ Yes ☐ No

Please explain _____

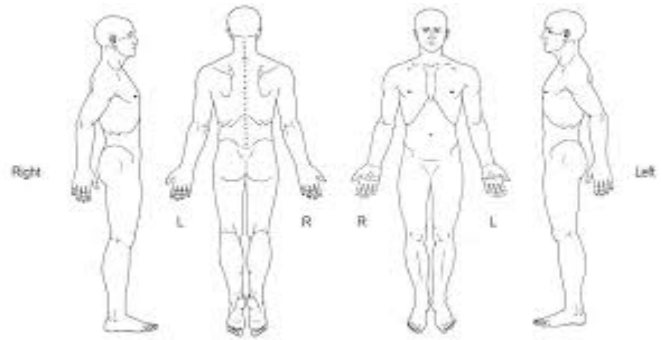
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____