

OFFICE POLICIES

Please read the following and Initial at the end of each statement:

Cancellation

A 24 hour notice of cancellations is greatly appreciated! A 2-hour notice is **required** for cancellation of an appointment, or I may be charged in full for the appointment. Payment is due before the next appointment. Voice message on the answering machine is acceptable for cancelling. _____

Tardiness

Appointment times are scheduled and usually cannot extend beyond the stated time to accommodate late arrivals. If needed the session will be shortened or denied at the office's discretion. I will be responsible for the full amount of the massage that was scheduled. Please be on time to the appointment. _____

I understand that this is strictly a professional massage and ANY illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. Immediate removal from the premises is required. I will be billed and liable for full payment of the scheduled appointment. I acknowledge that future appointments will no longer be accepted and documentation will be recorded and filed. _____

I have stated all my known physical conditions, medical conditions, and medications, and I will keep the massage therapist updated on any changes. _____

It is my choice to receive massage therapy/bodywork. I realize that the treatment I receive is for basic purpose of relaxation and/or relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and or strokes may be adjusted to my level of comfort. _____

I understand that massage therapists do not diagnose illness, disease, or any physical or emotional disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnoses, and that it is recommended that I see a primary health care provider for that service. _____

****If you have a specific medical condition or symptoms, receiving or performing massage may be contraindicated or require modification. A referral from your primary care provider may be requested prior to receiving massage.**

DISCLAIMER: This business will not be held liable for any injury or condition that arises from application of massage despite completion of this form. This form is intended as an assessment tool that is routinely used in the massage profession and serves as a guide for application of massage

Client Signature _____ Date: _____

Consent to Treatment of Minor: By my signature below, I am giving consent for my child or dependent to receive massage or bodywork.

Signature of Parent or Guardian _____ Date: _____



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