Path pathtorelaxation@sbcglobal.net 708-288-9065
To
Relaxation

Date _____

Notes:

_____
Last Name First Name Middle Initial

_____
Address City State Zip

_____ _____
Home number Work number

_____ _____
Occupation Birth Date

_____
E-mail Address

_____ _____
Doctor's name Doctor's number

Primary reason for massage _____

Medical condition (s) that a massage would affect_____

_____

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder.. The massage therapist does not prescribe medical treatment or pharmaceuticals nor perform any spinal manipulations. It has been made clear that massage therapy is not a substitute for medical exams or diagnosis and that it is recommended that I see a physician for any physical ailments that I might have.

I understand that if I fail to cancel 24 hours before my appointment that I will be charged for that time.

I understand that payment is expected at time of service. I am responsible for filing for insurance reimbursement.

I testify that I have listed all known medical conditions that massage might worsen, and I wave any claims I might have against massage therapist arising from worsening of any undisclosed medical conditions. I realize it is my responsibility to keep the massage therapist updated of any changes in my health status.

I agree to pay a minimum fee of $30.00 for each returned check

_____ _____
Signature Witness

_____ _____
Date Date