SALT AND STONE

MASSAGE THERAPY WAIVER

Personal Information

Name: _____ Phone: _____ DOB: _____

Address: _____ City: _____ Occupation: _____

Email: _____ Physician: _____

Emergency Contact(s): _____ Phone: _____

How did you hear about us? _____

Medical Information

Are you currently on any medications? If yes- please name.

_____

_____

_____

Are you currently pregnant? If yes - how far along? Please include any concerns or complications.

_____

_____

_____

Have you had any previous injuries or surgeries? Medical implants? If yes- please name.

_____

_____

_____

Please check any conditions below that apply to you.

__ cancer
__ headaches/migraines
__ arthritis
__ diabetes
__ joint replacements
__ high/low blood pressure
__ neuropathy
__ fibromyalgia
__ stroke
__ heart attack
__ blood clots
__ numbness/tingling
__ sprains/strains
__ dizziness

Please list any other medical concerns your therapist should be aware of.

_____

_____

_____

Massage Information

Have you ever had a massage? **YES or NO**

Do you prefer a silent treatment? **YES or NO**

Do you have any allergies, sensitivities, or scent preferences? If yes- please list.

_____

_____

_____

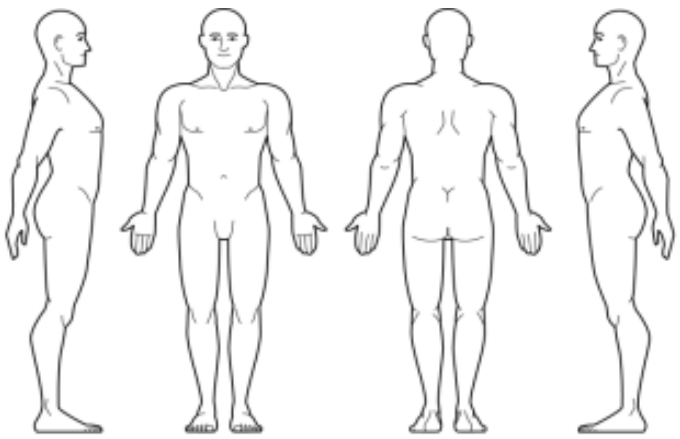
Are there any areas of the body you do NOT want to be treated?

_____

_____

Do you have difficulty lying on your front or back? If yes- please name: _____

Please circle any areas of discomfort or pain.



Informed Consent and Policies

I understand that the massage I receive is provided for the basic purpose of relaxation, stress reduction and relief of muscular tension. I further understand that the massage should not be used as a substitute for medical examinations, diagnosis, treatment and that I should see a physician or other qualified medical professional for physical ailments I am aware of. Massage therapists cannot prescribe or give medications to clients and any requests will result in a terminated treatment. Massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly in the above history form. I am aware in some situations it will be mandatory to receive doctors clearance prior to treatment, it is my responsibility to provide that documentation prior or at the time of treatment, not providing this documentation terminates the treatment and payment will still be collected. I agree to keep the therapist aware of any changes to my medical profile and understand that there shall be no liability on the therapists part should I forget to do so in the future. I am aware that massage can result in late onset muscle soreness known as "kickback pain or soreness" that can last 24-48 hours post treatment. Any illicit or sexually suggestive remarks or advances as well as rude and abusive behavior will not be tolerated and will result in an immediate termination of the session at any point. I authorize Salt and Stone Massage Therapy to perform massage therapy and any associated treatment add ons as well as to use lotions, oils and ointments on my body. I will be responsible for any payment of that full scheduled appointment regardless of termination. By signing this consent I am waiving all liability in case of accident, illness, or injury towards the therapist and Salt and Stone for past, current or future appointments

THE THERAPIST RESERVES THE RIGHT TO REFUSE SERVICE AT ANYTIME.

Initials: X_____

Cancellation/No-Show Policy

Any appointments canceled within 24 hours will be subject to a fee assessed up to 50% of the scheduled appointment. Fees will be waived if the appointment slot is filled. An appointment no-show will result in a fee assessed up to 100% of the scheduled appointment. Fees must be paid prior to rebooking - if you have any upcoming appointments they will be cancelled until the account is settled. To make arrangements for owing fees you can contact the clinic at anytime and speak to reception. If cancellations/no-shows persist it will become mandatory to confirm your next appointments with a credit card or deposit on your client profile. If a credit card is already on file it will be billed if we do not hear back. Any treatments booked are the responsibility of the client - we will provide courtesy reminders the day prior of all appointments.

***please note that group benefit plans do NOT cover cancellation/no show expenses**
***if you do not show up for your appointment we will call 5 min after the start time and if we do not hear back after 15min it will be an automatic no show with fees assessed up to 100%**

PLEASE REMEMBER THAT IF YOU DO NOT SHOW UP FOR YOUR APPOINTMENT YOUR THERAPIST DOES NOT GET PAID.

Preferred reminders: (please choose as many as you'd like) **Initials: X_____**

___Phone ___Email ___Text

Do you want to receive marketing material, promotions and discounts via text and email?

___YES ____NO

Print Name: _____ Sign Name: _____

Guardian Signature (for under 18): _____ Date: _____

SALT AND STONE

DIRECT BILLING CONSENT

Direct Billing Policy

Direct billing is a convenience to clients we are happy to provide at all times - but we cannot guarantee the insurance company will reimburse us, the service provider. Due to payout schedules insurance companies can decline or change payout amounts anytime before reimbursement ranging from one week to one month. They decline claims for a variety of reasons - and this can happen at the time of your appointment or after. In such instance, the client who received treatment, or the guardian is responsible for payment to the service provider.

YOU MUST PROVIDE A VALID CREDIT CARD OR DEBIT VISA TO KEEP ON FILE IF YOU WISH FOR US TO DIRECT BILL ON YOUR BEHALF.

We will not use your credit card before contacting the cardholder directly - you are welcome to pay any fees or outstanding balances with any form of payment we accept. If you do not respond to our forms of contact such as calls/voicemails and emails we will then charge your credit card on file.

Initials: X_____

Credit Card Number: _____ Expiration: _____

I, _____, authorize Salt and Stone Massage Therapy to charge my card if needed, for treatment costs and fees not covered by insurance. I understand my information will be saved permanently for future use. At anytime I can cancel this agreement - in turn it will also disable direct billing for future appointments.

Client Name & Signature: _____ Date: _____

Primary Insurance:

Insurance Provider: _____
Member ID: _____ Group Number: _____
Name of Policy Holder: _____ Policy Holder Birthday: _____

Secondary Insurance: (please note not all secondary plans are billable)

Insurance Provider: _____
Member ID: _____ Group Number: _____
Name of Policy Holder: _____ Policy Holder Birthday: _____

Need Help? If you still need assistance please ask reception!

Is the client under 18 with primary and secondary insurance? Whichever parent is older is responsible for primary, and the younger parent for secondary.
Do you have greenshield or VAC? They only have a Member ID NOT a Group Number, please include the beginning letters.
Not sure who the policy holder is? It is whoevers plan it is, could be yourself, a spouse, a parent, etc.
Group Number and Plan/Policy Number are the same! Member ID and Certificate Number are the same!
Do you have empire life? We will require the Divison Number that can be added to any line above.