



Professional Massage/Spa Services Program

CLIENT SERVICES AGREEMENT FORM

I, _____, in reading and signing this form understand the rules and regulations of the professional program. The massage/spa procedures, general benefits and contraindication for massage/spa services, and possible alternatives have been explained to me. All massage therapists participate as independent contractors in the professional program and are nationally certified in massage therapy. Referrals will be made to another qualified therapist if more specific treatment is required. I understand that all massage appointments are therapeutic and not sexual in any way. If you wish to report any misconduct contact either Synergy Healing Arts Center & Massage School Inc. at 877-372-6617 or the National Certification Board at 800-296-0664.

Appointments are reserved with a Visa, Master Card, Discover, American Express credit or debit card number. All card numbers will be kept on file securely. Your card will be charged the day of your appointment. Cash payment is accepted when the office is open. Gratuities are appreciated, but not required and are to be paid directly to the massage therapist. I understand when I am late, I will receive the remainder of the appointment time and that I must cancel at least 24 hours prior to an appointment or my card on file will be charged. If I do not show up for an appointment my card on file will be charged unless written emergency documentation is presented. Prepaid appointments are not refundable.

Weather Cancellation Policy: Synergy Healing Arts Center & Massage School Inc. will announce on the office answering machine 2 hours prior to any scheduled appointment if it is to be cancelled. Please call Synergy or your therapist if there has been any inclement weather within 24 hours of a scheduled appointment.

Please wear comfortable clothing & bathe prior to the massage on the day of your appointment. Please arrive 15 minutes prior to your first appointment as all new clients must complete a Health History form along with this Services Agreement Form prior to the massage appointment. Please schedule your appointment so all medications have been taken at least 2 hours prior to your appointment. Do not consume any alcohol before your appointment. Conversation during your massage is your decision. Please inform the therapist of the level of conversation you desire for your relaxation & therapeutic needs to be met. For safe massage/spa treatment clients taking circulatory medications must agree to have their BP/HR assessed prior to a Steamy Wonder treatment or during the early part of the massage.

I understand that the massage/bodywork/spa services I receive are for the purpose of stress reduction, relief from muscular tension, spasm, or pain, to increase circulation, to exfoliate the skin and detoxification of the body. If I experience any pain or discomfort, I will immediately inform the massage/bodywork practitioner so that the pressure or methods can be adjusted to my comfort level. I understand that massage/bodywork professionals do not diagnose illness or disease or perform any spinal manipulations, nor do they prescribe any medical treatments, and nothing said or done during the sessions should be construed as such. I acknowledge that massage is not a substitute for medical examination or diagnosis and that I should see a health care provider for those services. Because massage/bodywork should not be performed under certain circumstances, I agree to keep the massage practitioner updated as to any changes in my health profile, and I release the massage professional from any liability if I fail to do so.

This form and all client records are retained on file by the independent contractor in a locked cabinet in a locked room. A client may request to view their client records.

Client's Signature _____ Date _____

Independent Contractor _____ Date _____

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Consent to Treat a Minor

By my signature I authorize the Professional Program to provide massage/bodywork to my child or dependent.

Signature of Parent or Guardian _____ Date _____

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Release of Information Request:

I release the following massage therapist, _____,
To consult with _____
regarding my health & treatment if requested.

Client Signature: _____ Date: _____

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Pregnancy Release

Due Date: _____ Total # of Pregnancies: _____

Name of OB/GYN Physician/Midwife: _____

Phone/Email of OB/GYN Physician/Midwife: _____

Describe your general health during this and any previous pregnancies:

I am having a healthy pregnancy and hereby give _____
permission to perform massage/bodywork on myself without any written medical approval.

Client Signature: _____ Date: _____