

Name: _____ Date: _____

Check if: CMC Employee (Badge # _____) AH Corporate Employee CMC Governing Board

Sex: M F Birth Date: _____ E-mail: _____

Street Address: _____ City/Zip: _____

Phone: (Hm) _____ (C) _____ (Wk) _____

IN CASE OF EMERGENCY
Person to call & Relationship: _____ Phone: _____

IMPORTANT: Please read each statement carefully and sign below indicating that you understand and accept the following policies, procedures and waivers:

I give consent to receive massage therapy and agree to pay the fee upon completion of this service. As a courtesy to the massage therapist I will cancel my appointment at least 24 hours in advance, if needed. I understand there is a \$10 fee for not showing up for my appointment. True emergencies will be handled accordingly between client and Wellness department personnel. I agree to pay the full fee for my scheduled appointment if I am late and understand I may not receive a full-length massage. I understand that if the Licensed Massage Therapist feels I am not appropriate to receive the massage services, the Wellness Center reserves the right to deny service.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the licensed massage therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or about which I am aware.

I understand that licensed massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have no known medical conditions that would be contraindicated for receiving massage. I agree to keep the licensed massage therapist updated as to any changes in my medical condition that may affect my ability to safely receive massage.

I waive, release, and forever discharge Castle Medical Center and their programs/classes and associates, partners, agents, and employees of and from any and all matters, claims and suits of every kind whatsoever as a result of my receiving seated massage therapy. I further agree to assume any and all risks and to release and hold harmless Castle Medical Center and their associates, partners, agents, and employees who through negligence, carelessness or otherwise might be liable to me for any personal injuries, loss, cost, wages, and any and all other damages resulting from or connected to my receiving massage services.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I, _____, have reviewed and agree to all the above terms.

Signature: _____ Date: _____

If under age 18, Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____