Massage Center of Niagara, LLC ~ Gina Puglisi, LMT

Name_____ Date_____

Address_____

City_____ State_____ Zip code_____

Cell #_____ Text Y / N Home #_____

Date of birth_____ Referring Physician_____

In case of emergency notify_____ Phone #_____

Email_____How did you hear about us?_____

If client is a minor: permission is hereby given by me to the massage therapist of this office to treat this client. I am her/his legal guardian.

Guardian name (print)_____ Sign_____ Date_____

Do you suspect that you might be pregnant? Yes / No

Are you taking any medications?_____

Are you currently taking any medications for the following?

____Blood thinners ____Muscle relaxants ____Birth control ____Anti-inflammatory

____High blood pressure ____Pain relievers ____Diabetes ___Allergies

Have you had any surgical procedures?_____

_____

Do you have any injuries or allergies you feel your massage therapist should be aware of?

_____

Have you ever had a massage before? Yes / No

What are your goals/expectations for this massage session?_____

_____

Please read the following and sign below: I understand that massage is not a replacement for medical care and that no diagnosis will be made.
Signature _____ Date_____

Massage Center of Niagara, LLC ~ Gina Puglisi, LMT

I hereby request and consent to the performance of massage therapy on me (or by the client named below, for whom I am legally responsible) by Massage Centre of Niagara, LLC, Gina Puglisi, LMT.

I have had the opportunity to discuss with the massage therapist and/or with other office or clinic personnel the nature and purpose of massage therapy. I understand that results are not guaranteed. I have been informed of other health care options that may also help my condition.

I understand and am informed that in the practice of massage therapy there are some risks to treatment, including but not limited to: bruising, muscle soreness. I do not expect the therapist to be able to anticipate and explain all risks and complications, and I wish to rely upon the therapist to exercise judgment during the course of the procedure which the therapist feels at the time, based upon the facts then known to her/him, in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

APPOINTMENT POLICY

- If you cannot keep your appointment for any reason, we require 24 hours prior notice for any cancellation/rescheduling. You are still responsible for the cost of the full session if you fail to give 24 hours prior notice or a No Call/No Show for an appointment.
- I attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment or reschedule for another day. You will still be responsible for the full payment of that session.

FINANCIAL POLICY

- Acceptable forms of payment cash or credit card. Credit cards accepted are MasterCard, Visa, and Discover.

Name (print)_____ Signature_____ Date_____

Guardian Name (print)_____ Signature_____