**Healing Solutions Inc Policies**

**Release of Liability**

1. The above information is accurate. I understand the Massage Therapist is providing bodywork that is within their scope of practice. I hereby consent for my therapist to treat me with massage therapy, energy work, cupping aromatherapy, and yoga for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my massage therapist. I understand that massage therapy and integrative bodywork therapies are provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow. I acknowledge that the therapist is not a physician and does not diagnose disease or prescribe drugs and that they are not a substitute for medical care.

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks. I agree to alert my practitioner immediately of any physical/emotional changes as they occur so treatment can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain I experience during or after a session. I have completed the intake form as provided by Healing Solutions Inc and disclosed to my therapist all of my known medical conditions that may impact my ability to be a client. It is my responsibility to keep the massage therapist updated on changes in my health and medical conditions. I understand that there shall be no liability on the therapists part should I forget to do so. I have read the above noted consent and I have had the opportunity to question the contents and my therapy. I confirm my consent to treatment and intend this consent to cover all of my treatments at Healing Solutions Inc. I hereby waive and release Suzette Skidmore, Rachel Farmer, and Healing Solutions Inc form any and all liability past, present, and future relating to massage therapy and all forms of integrative bodywork.

**Communication**

1. I (the client) understand that massage/ bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during a session, I will ***immediately*** inform the practitioner so that pressure or strokes may be adjusted to my level of comfort. I understand that giving feedback to my practitioner helps to create a treatment that works best for me. Any changes I need will be communicated to the practitioner. (i.e. too cold, too hot, want different music, pressure is too light)
**Medical Background**
2. I understand if I have a specific medical condition or specific symptoms, massage/ bodywork may be contraindicated. A referral from my primary care provider may be required prior to service being provided.

I understand that massage/ bodywork practitioners 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 a session should be construed as such.

I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioners part should I fail to do so. I take responsibility for alerting my practitioner of any physical, mental or emotional changes that occur with my health.
**Inappropriate Behavior**

1. I (the client) 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 for the scheduled appointment.
**Therapeutic Grade Essential Oils**
2. I understand my responses to therapeutic grade oils are based upon my unique body chemistry. Although allergic reaction to therapeutic grade essential oils are rare, I will contact my physician should any allergic reaction become a concern to me.
**Scheduling, Cancellations & Payment**
3. I understand that I need to be on time for an appointment. If I am late, the session will be shorter, allowing the practitioner to finish on schedule. I agree to provide 24 hours notice if I need to cancel an appointment or reschedule. I understand that Healing Solutions Inc has a 24-hour cancellation policy. I agree to pay any fees, subject to change, associated with late cancellation, lack of notification or for missed appointments per the cancellation policy. See cancellation policy for specific guidelines. Methods of payment accepted by Healing Solutions Inc. are Visa, MasterCard, check, or cash. Any returned check will be assessed a return check fee of $ 35.00.

**Confidentiality & Privacy Policy**

1. I understand all information will be kept confidential. I have read the privacy policy for Healing Solutions Inc and understand and agree to the terms.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_