

*****Please Print Neatly!*****

ADVANCED MASSAGE THERAPIES CLIENT INFORMATION FORM

Therapist: _____

Location: _____

Name _____ Date ____/____/____

Address _____ City _____ State _____ Zip _____

Phone (W) _____ (H) _____ (C) _____ E-mail _____

Male _____ Female _____ Date of Birth ____/____/____ Weight _____ Height _____ Contact Lenses? ___Yes ___No

Marital Status: Single ___ Partner ___ Your Employer _____ Occupation/Job Title _____

Emergency Contact Name/Relationship _____ Emergency Contact Number _____

Driver's License State: _____ Number: _____ Exp: _____ Are you currently receiving medical or chiropractic care? ___Yes ___No

If you are receiving medical or chiropractic care, explain: _____

Name of physician(s) or therapist(s) _____

Are you taking any medications (prescription, over-the-counter, herbal)? ___Yes ___No If yes, please list: _____

How did you hear about us? ___Ad ___Gift Cert. ___Internet ___Phone Book ___Other _____ Referral (who?) _____

Are you currently contagious or feel like you might be coming down with a cold or flu? ___Yes ___No Recovering? ___Yes ___No

Have you ever experienced any of the following? Please use 'C' for current, 'P' for past, 'S' for sometimes. Leave blank if never.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Abdominal pain | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Circulatory problems | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Joint pain | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Ringworm |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Acid reflux | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Constipation | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Joint replacement | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Sciatica |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Adhesions or scarring | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Depression | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Low blood pressure | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Scleroderma |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S AIDS/HIV | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Diabetes | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Lymphoedema | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Scoliosis |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Allergies | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Diverticulitis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Migraines | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Skin allergies |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Alzheimer's | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Epilepsy | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Multiple sclerosis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Skin diseases |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Amputation | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Fibromyalgia | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Muscle spasms | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Stiff neck |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Anemia | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Foot pain | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Myofascial Pain Syndrome | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Stress |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Aneurism | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Frozen shoulder | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Neck pain | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Sprains/strains |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Anxiety | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Golfer's elbow | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Neuropathy | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Sports injury |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Arthritis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Headaches | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Numbness | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Surgery |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Auto accident | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Heart attack | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Osteoporosis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Stroke |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Back pain | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Heart problems | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Palsy | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Swollen feet/legs |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Blood clots | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Hematoma | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Panic attacks | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Tendonitis |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Bone fractures | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Hemophilia | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Paralysis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Tennis elbow |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Breathing problems | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Hernia | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Parkinson's | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Tingling |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Bursitis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Herniated discs | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Phlebitis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Tumors |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Burns | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Hepatitis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Plantar fasciitis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Varicose veins |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Cancer | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Herpes | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Postural problems | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Whiplash |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Carpal tunnel | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S High blood pressure | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Post traumatic stress | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Other _____ |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Cellulitis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Hip pain | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Pressure sensitivity | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Other _____ |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Chronic fatigue | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Immune suppression | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Psoriasis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Other _____ |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Chronic pain | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Insomnia | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Rashes | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Other _____ |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Claustrophobia | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Irritable bowel | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Raynaud's syndrome | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Other _____ |
| | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Jaw/TMJ pain | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Rotator cuff injury | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Other _____ |

For Women Only:

- | | | |
|--|--|--|
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Amenorrhea | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Fibrocystic breasts | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Menopause |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Breast implants | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Hysterectomy | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S New mom birth date ____/____/____ |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Breast pain | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S High risk pregnancy | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Ovarian cysts |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Breast reduction | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Infertility | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S PMS |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Breast reconstruction | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Inverted nipples | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Pregnant due date ____/____/____ |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S C-section date ____/____/____ | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Lumpectomy | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Urinary incontinence |
| <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Endometriosis | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Mastectomy | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Urinary urgency/frequency |
| <i>Continued on Page 2.....</i> | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Menstrual cramps | <input type="checkbox"/> C <input type="checkbox"/> P <input type="checkbox"/> S Trying to be pregnant |

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ADVANCED MASSAGE THERAPIES CLIENT INFORMATION FORM

Page 2 of 6 Name: _____ Date: _____

Accidents, Injuries, or Surgeries:

Less than 5 years ago (include dates) _____

More than 5 years ago (include dates) _____

Are you here for injury treatment? Yes No Date of Injury: ____/____/____ Auto Work Other

Please describe your current issue: _____

Date it began: _____ How did it begin? _____

What makes it better?

What makes it worse?

Any range of motion restrictions?

What treatment(s) have you had for this condition? _____

Rate your level of pain: No pain 1 2 3 4 5 6 7 8 9 10 unbearable pain

Describe your current pain/symptoms:

Shooting Throbbing Dull Sharp/Stabbing
 Burning Numbness Soreness Tingling other _____

How often are your symptoms present?

Constantly Frequently Occasionally Intermittently

Can you perform your daily **home** activities w/out pain w/pain

Explain _____

Can you perform your daily **work** activities w/out pain w/pain

Explain _____

How is the quality of your sleep? _____ Hours of sleep lost _____

Is there any swelling or tendency to swell anywhere in your body? _____

Are there any areas of inflammation? _____

Continued on page 3...

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ADVANCED MASSAGE THERAPIES CLIENT INFORMATION FORM

Page 3 of 6

Name: _____ Date: _____

Do you have any site restrictions due to:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Area of infection | <input type="checkbox"/> Incisions | <input type="checkbox"/> Skin sensitivity |
| <input type="checkbox"/> Bone or spine metastasis | <input type="checkbox"/> I.V. | <input type="checkbox"/> Rash or skin condition |
| <input type="checkbox"/> Catheter | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Drains or dressings | <input type="checkbox"/> Open wounds | <input type="checkbox"/> Tumor site |
| <input type="checkbox"/> Fracture history | <input type="checkbox"/> Other device | <input type="checkbox"/> Ostomy |
| <input type="checkbox"/> History of blood clots or phlebitis | <input type="checkbox"/> Port | <input type="checkbox"/> Other _____ |

Do you have any pressure restriction due to:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Fragile/sensitive skin | <input type="checkbox"/> Recent surgery |
| <input type="checkbox"/> Area of pain or burning | <input type="checkbox"/> Fragile skin | <input type="checkbox"/> Steroid medication |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Infection or fever | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Bone or spine metastasis | <input type="checkbox"/> Low platelet count | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lymph edema | |

Do you have any position restrictions due to:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Incision | <input type="checkbox"/> Ostomy |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Medication | <input type="checkbox"/> Sinus issues |
| <input type="checkbox"/> Discomfort _____ | <input type="checkbox"/> Medical devices _____ | <input type="checkbox"/> Tender skin |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Tumor site |

Has your medical condition or medical treatment affected any of the following functions in your body?

- | | | |
|---------------------------------------|---------------------------------|--|
| <input type="checkbox"/> Balance | <input type="checkbox"/> Heart | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Kidney | <input type="checkbox"/> Nervous system |
| <input type="checkbox"/> Blood counts | <input type="checkbox"/> Liver | <input type="checkbox"/> Range of motion |
| <input type="checkbox"/> Energy level | <input type="checkbox"/> Lungs | <input type="checkbox"/> Other _____ |

For Cancer Patients Only:

When were you first diagnosed with cancer? _____ What type(s)? _____

Where was/is it located? _____

Are you being treated now? _____

What treatments have you had and when? _____

Did your treatment include any removal or radiation of lymph nodes? If yes, how many and where? _____

Did your treatment include radiation therapy? If yes, where and what type? _____

How is your energy level and sleep? _____

Have you had issues with lymphedema? _____

Have you tried any treatment for it? _____

Notes: _____

Continued on page 4...

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ADVANCED MASSAGE THERAPIES CLIENT INFORMATION FORM

Page 4 of 6

Name: _____ Date: _____

Heavy Moderate Light None

Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

What type(s) of exercise? _____

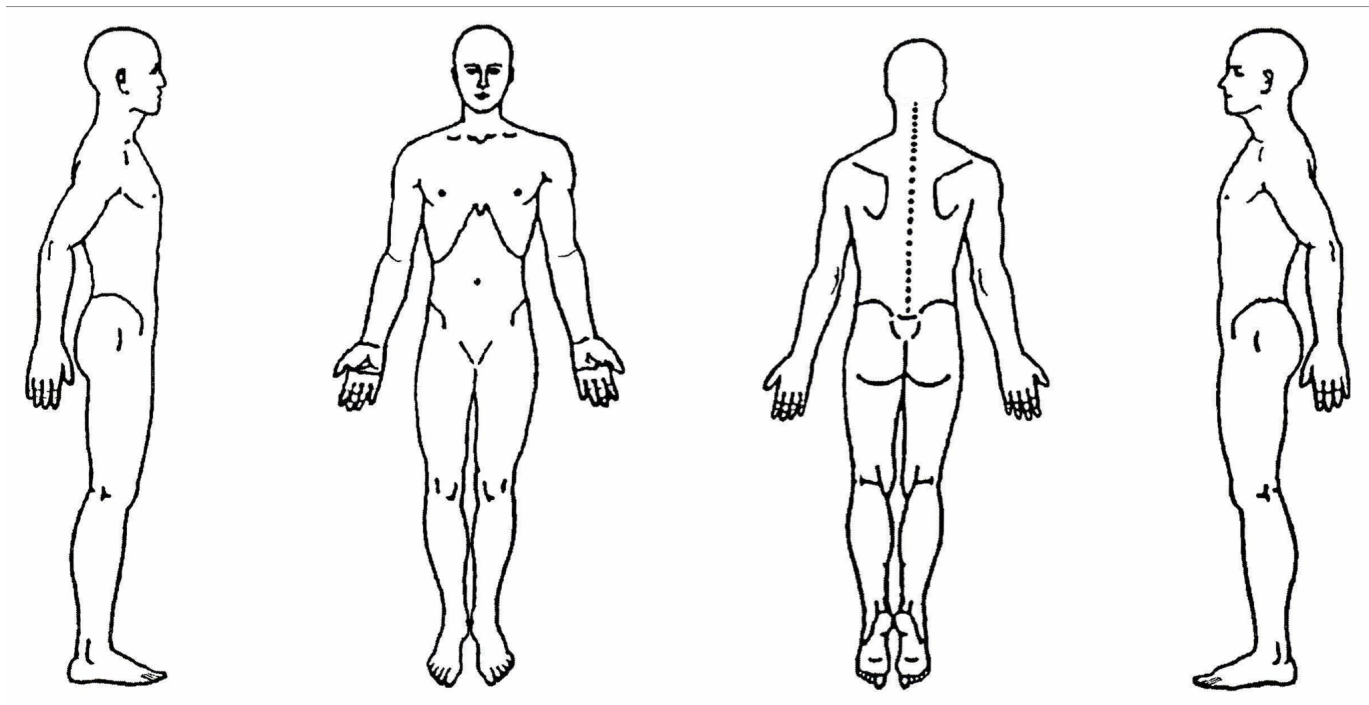
How often? _____

- Have you ever had massage / bodywork before? Yes___ No___ When?_____ Frequency?_____
- What did you especially like or dislike? _____
- Why have you come for massage therapy? _____
- What are your goals with massage therapy? _____

1. How do you feel right now (physically, emotionally, mentally)? _____

Mark on the pictures where you have symptoms: Pain **X** Numbness **+** Tingling *****

Circle areas you do not want to be touched; genitals are never touched.



Notes: _____

Continued on page 5...

PLEASE TAKE A MOMENT TO CAREFULLY READ THE FOLLOWING INFORMATION AND SIGN WHERE INDICATED TO SHOW THAT YOU HAVE READ, UNDERSTAND, AGREE, AND CONSENT TO OUR POLICIES.

Consent for Therapy:

- If I experience any pain or discomfort during any session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. Also, I will immediately notify my therapist should I have any questions or concerns following therapy.
• I further understand that massage / bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.
• Because massage / bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.
• It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be responsible for full payment of the scheduled appointment.
• I agree to the release of information and records for medical and / or insurance purposes and authorize Advanced Massage Therapies, Inc. to obtain and/or release any information to / from my healthcare providers concerning my health.
• If my employer has sent me for treatment, I authorize Advanced Massage Therapies, Inc. to obtain and/or release any information to/from my employer concerning my health.
• I understand that I may have cupping on my body. Temporary bruising or redness ("hickies") lasting a few days is a common side effect of cupping.
• If I experience any pain or discomfort during any session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort. Also, I will immediately notify my therapist should I have any questions or concerns following therapy.
• Audio, video, and photographic recordings may be made to mark the progress of my therapy (before and after for postural changes, etc.) and with facials (before and after for wrinkle reduction), or testimonials, may be used for educational purposes and promotion of Advanced Massage Therapies, Inc.
• I understand that certain conditions and medications may be contraindicated for certain therapies. They include, but are not limited to: bleeding disorders, use of anticoagulants, medical implants, incisions, open wounds, drains, or dressings, skin sensitivity, rash, or other skin conditions, inflammation, risk of infection, etc.
• 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.
• I do not have any contagious disease, nor have I been exposed to anyone who is contagious or symptomatic within the past 14 days.
• I have not visited any location known to be a "hot spot" for any contagious disease in the past 30 days.
• I understand that this business and my massage therapist cannot be held liable for any exposure to any contagion caused by misinformation on this form or the health history provided by me.
• By signing below I agree to release the massage therapist and business from any and all liability for the unintentional exposure or harm due to COVID-19 or any other infectious/contagious disease.

For Women Only: Consent for Breast Therapy:

- This does not mean that you will have this therapy done, but should we ever have the need to do this therapy, we have your permission on file.
• I understand that breast therapy may be done with my advanced notification and permission if indicated. It is indicated for, but not limited to: the treatment of scarring, pain, and dysfunction of the breast, chest, back, shoulder, neck, and head areas.
• I understand that certain conditions, medications, and treatments (radiation, chemotherapy, etc.) or may be contraindicated for this therapy. They include, but are not limited to: medical implants, incisions, open wounds, drains, or dressings, skin sensitivity, rash, inflammation, risk of infection, etc.
• I understand that breast work not sexual in nature. I understand that I may refuse or terminate this therapy at any time.

I have read, understand, and agree to the above following policies, and I consent for therapy at Advanced Massage Therapies, Inc.

Client or guardian signature: _____ Date: _____

Signature of person responsible for payment if different from above: _____ Date: _____

• NEW CLIENT INFORMATION

1. Please save time by downloading, printing, and filling out the New Client Form and bring it in with you on your first visit. If you are unable to print out the form, please call to let us know in advance (so we know to expect you) and plan to arrive at least 20 minutes prior to your scheduled appointment time in order to fill it out in our office. If you do not arrive early, the time taken to fill out your form is included within your scheduled appointment time, and will therefore result in a shortened appointment. Completion of the New Client Form is required for all clients, and we will not perform services without a full health intake.
2. We endeavor to provide a caring and relaxing environment for your massage experience. We ask that clients' voices be kept at a quiet level.
SILENCE YOUR PHONE UPON ARRIVAL BY TURNING IT OFF OR PUTTING IT ON AIRPLANE MODE. If you need to be available take a call during your session, please let your therapist know, and put your phone on vibrate.
3. Out of respect for your therapist and others who may be following you, please refrain from wearing perfume or smoking before your appointment. We ask that you be clean and free from strong odors such as perfume, smoke, or body odor. Clients with strong scents may be refused service and will be responsible for payment in full for the appointment.

• APPOINTMENTS / CANCELLATION / RESCHEDULING POLICY

1. Appointments are an agreement to reserve a portion of available office time. Please arrive a few minutes early. We cannot guarantee full service time for late arrivals, and you will be responsible for the full amount of your session. Upon arrival, if you request a shortened service, you are responsible for the full amount of the scheduled service. Your session time includes consultation, assessment, treatment, dressing time, and check in/check out.
2. **All appointments require pre-payment in full and are non refundable. There are no refunds given for canceled or missed appointments. All credit/debit cards will be charged a 5% non refundable surcharge.** Clients who have pre-paid for packages will have the full amount of the missed appointment deducted from the package.
3. **Appointments may be rescheduled once with a minimum of 24 hours' notice or by noon on Friday for Monday appointments. If a client needs to reschedule more than once, a fee of 50% the value of the appointment will be charged for the rescheduling. Rescheduling must be within six weeks of the original appointment, otherwise it is considered a cancellation, and the full fee for the new appointment must be pre-paid.** Rescheduling for 1/2 day (3-4 hours service) require a minimum of 5 business days' notice, and full day services (any time over 4 hours) require 10 business days' notice for rescheduling.

• ONLINE BOOKING

All clients are required to prepay in full for appointments, and all appointments are non-refundable. **All credit/debit cards will be charged a 5% surcharge. There are no refunds given for canceled or missed appointments. VERIFY THE APPOINTMENT TIME/DATE TO AVOID ERRORS!!**

• APPOINTMENT CONFIRMATIONS

Confirmation of booking emails are automated by the computer, and no reply is available. If you do not receive an email, check your spam folder. Appointment reminder texts are sent by the computer which **accepts only "yes" or "no" for a response.** Please do not respond with any other message or an abbreviated "y" or "n". Any response other than "yes" or "no" is not accepted by the system. Your appointment will change color on the computer screen to indicate confirmation or cancellation; **responses are not read by a human.** If you need to communicate any additional information, please call the office at 770-834-4599. **VERIFY THE APPOINTMENT TIME/DATE TO AVOID ERRORS!!**

• CHILDREN

Children receiving treatment: Children under the age of 18 are required to have a parent or guardian sign the health intake form and be present for the first appointment. We prefer that the parent or guardian be present in the treatment room at all sessions for education on the child's therapy.
Clients who wish to bring children along for their session: Children must be well behaved, be able to sit quietly, and self entertain during your session. Please no food or drinks, as spills and messes often occur. We have bottled water available. For younger children, please make arrangements for child care.

• HEALTH INSURANCE

Some health insurances cover for medical massage therapy. Advanced Massage Therapies, Inc. does not bill insurance directly. If your insurance provider covers for therapy, payment in full is expected at the time of scheduling, and it is your responsibility to file with your insurance for reimbursement.

• GIFT CERTIFICATES

Gift certificates sales are final, and no refunds are given. They are not redeemable for cash. Expiration dates are final, so please schedule your appointment well in advance of the expiration date. If the gift certificate holder would like to exchange for another service, the gift certificate will be exchanged for the dollar amount paid and put toward another service. Gift certificates must be presented at time of service. Missed appointments or cancellations less than 24 hours in advance (or by noon on Friday for Monday appointments) will have the full amount of the service deducted from the gift certificate.

• PAYMENT

Pre-payment for services is required, and is non-refundable. Pre-payment is assigned to an individual client's account, and is not transferrable to another client. We accept Visa, Master Card, or Discover, cash, and in-state checks with a valid driver's license matching the address on the check. We also accept Health Savings Account (HSA) and Flexible Spending Account (FSA) cards. **All credit/debit cards will be charged a non refundable 5% surcharge.** Each bank returned check will be charged \$30.00. Additional court, attorney, or collection agency fees may be charged if applicable.

• CORPORATE ACCOUNTS

Missed appointments or cancellations less than 24 hours in advance (or before noon on Friday for Monday appointments) will be billed for the full fee. Balance is due 30 days from the invoice date. A \$50.00 re-billing fee plus 10% interest will be charged each month until balance due is paid. All credit/debit cards will be charged a non refundable 5% surcharge.

I have read, understand, and agree to the above following policies, and I consent for therapy at Advanced Massage Therapies, Inc.

☞ Client or guardian signature: _____ Date: _____

☞ Signature of person responsible for payment if different from above: _____
Date: _____