pilatesofgreenville.com

12-A Clarendon Avenue, Greenville, SC 29609 864-242-1227

Client Waiver of Liability / Informed Consent

I hereby affirm that I am in sound physical condition and able to participate in a physical exercise program which may be rigorous at times. I recognize that participation in these programs of exercise is voluntary on my part, and that there are inherent risks which I hereby assume for myself, my heirs, and assigns. I recognize that many changes may occur as a result of these exercise sessions, including possible short-term aggravation of some symptoms: feelings of lightheadedness, increased energy, mood changes, etc.. Pilates of Greenville, LLC, and/or Clare Dillon-Palma, and/or Independent Contractors shall not be liable for any injuries or damages to any participant, or the property of any participant, or be subject to any claim, demand or injury, or damages whatsoever, including without limitation, those damages or injuries resulting from acts of negligence for the part of Pilates of Greenville, LLC, Clare Dillon-Palma, and/or Independent Contractors.

In consideration of my acceptance as a participant in such activities, I expressly waive, release and discharge Pilates of Greenville, LLC, Clare Dillon-Palma, Independent Contractors, officers, directors, employees, substitutes, agents and successors, from any obligations, liabilities, claims, demands, costs, and expenses, including attorney fees, arising out of, or in connection with, any bodily injury, however caused, occurring during or after my participation in the exercise program, workshops, and certification programs.

I hereby affirm that I have read, fully understand, and accept the above.

Signature_____ Date: _____ / _____ / _____

Print Name_____

Witness (By Your Pilates Instructor) _____

.....

Address _____

_____

Phone (H) _____ (W) _____

(Cell)_____ Date of Birth _____ / _____ / _____

E-Mail Address _____

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Client Medical History

Name:_____ Date: ____ / ____ / ____

Do you now, or have you ever been treated for any of the following conditions:
(Please circle and explain where applicable)

ARTHRITIS	CHRONIC ILLNESS	OSTEOPOROSIS
SMOKER	DIABETES	LIGHTHEADED/DIZZY
EATING DISORDERS	STROKE	HEART ATTACK/HEART DISEASE
HIGH BLOOD PRESSURE	LUNG PROBLEMS	SEIZURES

ORTHOPEDIC PROBLEMS: (Circle) Back Feet Joint Knee Neck Other

Please Explain:

List medications:_____

List any accidents or injuries (falls, automobile, athletic, childhood, etc.)

Please explain:_____

Surgeries & Dates:

Have you been released to exercise? Yes No

List medical professionals you are currently seeing for chronic problems.

Please include family practitioner, osteopaths, chiropractors, massage therapists, etc.

_____ _____

Name Phone Name Phone

_____ _____

Name Phone Name
Phone

May we phone them to discuss your exercise program? Yes No

Emergency Contact: Name_____Phone#_____

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CANCELLATION POLICY

No shows and cancellations less than 24 hours will be charged a full session fee. This applies to individual sessions, duo sessions, trio sessions, and mat classes. Please make changes to your schedule at least 24 hours in advance to allow the time slot to be filled.

Discount mat class cards (10 classes) will expire in 120 days (4 months) from the date of purchase.

I have read and agree to the above policy conditions.

_____ Date: ____ / ____ / ____
Signature

_____ Date: ____ / ____ / ____
Witness (By Your Pilates Instructor)