CANCELLATION POLICY

NEW MOON
Energy & Massage Therapy

We are committed to providing all of our clients with exceptional care in a timely manner. For this reason, we have instituted a 24-hour cancellation policy for all appointments. The office needs to be notified 24 hours prior to the appointment date in order to avoid a 100% cancellation or no-show fee for any therapy visits. We appreciate your understanding and cooperation.

CLIENT CONSENT

I have read this policy and understand that I need to provide at least 24 hours notice when rescheduling or cancelling an appointment. If I fail to contact the office at least 24 hours in advance I will be charged the appropriate cancellation fee.

CLIENTS NAME _____

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

Credit Card Information:

☐ Visa ☐ Mastercard ☐ American Express ☐ Discovery

CARD NUMBER _____

EXP DATE _____

NEW MOON
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I hear by consent to and authorize Amber Pouliot of New Moon Energy & Massage Therapy LLC to perform massage therapy.

I have voluntary elected to undergo this massage therapy procedure after the nature and the purpose of this treatment has been explained to me, along with the risks and hazards involved, by Amber Pouliot of New Moon Energy & Massage Therapy LLC.

I acknowledge that the therapist is not a physician and does not diagnose medical conditions. I understand that massage therapy is not a substitute for a medical examination or treatment.
It is recommended that I attend my personal physician for any issues that I might be experiencing.

I have read and understood the post-treatment home care instructions and understand how important it is to follow all the instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home post-treatment care, I will consult my therapist immediately.
I have also, to the best of my knowledge, given an accurate account of my medical history, including allergies or prescription drugs or products that I am currently ingesting or using topically.

I have read and understood this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement.
I do not hold the massage therapist, whose signature appears below, responsible for any conditions that were present, but not disclosed at the time of this massage therapy procedure, which may be affected by the treatment performed today.

CLIENTS NAME _____

SIGNATURE _____ DATE _____

THERAPIST NAME _____

SIGNATURE _____ DATE _____

INTAKE FORM PART 1

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CLIENTS NAME _____

AGE: _____ PHONE NUMBER _____

EMAIL: _____

ADDRESS: _____

EMERGENCY CONTACT _____

OCCUPATION _____

Have you ever received Massage Therapy?

☐ Yes ☐ No

Have you consumed alcohol in last 72h?

☐ Yes ☐ No

Do you have any allergies or sensitivities?

☐ Yes ☐ No If Yes, what kind? _____

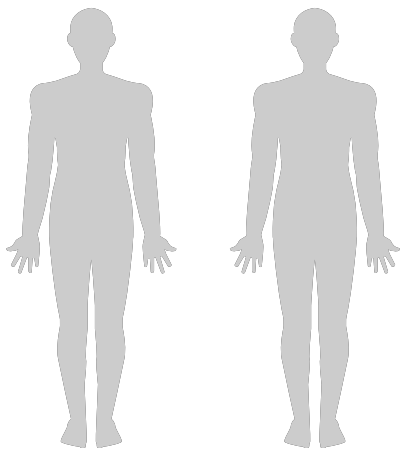
Are you currently pregnant?

☐ Yes ☐ No

Do you suffer from chronic pain?

☐ Yes ☐ No

Please indicate/list any areas of areas of the body you do NOT want massage



Front Back

INTAKE FORM PART 2

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Do you experience any of Joint Pain / Soft Tissue

- [ ] Neck
- [ ] Upper Back
- [ ] Shoulders
- [ ] Midback Area
- [ ] Low Back
- [ ] Arms
- [ ] Hips
- [ ] Legs / Knees
- [ ] Feet
- [ ] Joints

Do you experience any of the conditions?

- [ ] Headache / Migraine
- [ ] Ear Problems
- [ ] Vision Problems
- [ ] Vision Loss
- [ ] Hearing Loss

Do you experience any of the conditions?

- [ ] Skin Conditions
- [ ] HIV
- [ ] Herpes
- [ ] Hepatitis

Cardiovascular conditions:

- [ ] Heart Attack
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Heart Disease
- [ ] Edema

Other possible conditions:

- [ ] Allergies
- [ ] Epilepsy
- [ ] Asthma
- [ ] Cancer
- [ ] Diabetes

INTAKE FORM PART 3

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Do you have any of the following?

- [ ] Sun Burn
- [ ] Cold
- [ ] Burns
- [ ] Pain
- [ ] Bruises
- [ ] Rush
- [ ] Cuts
- [ ] Heart Conditions
- [ ] High/Low Pressure
- [ ] Broken Capillaries

Please specify any medical conditions, injuries or surgeries that were not mentioned:

Please list any medications you take:

Please list any focus areas and preferred pressure level:

CLIENTS NAME _____

SIGNATURE _____ DATE _____