SOL SANTA CRUZ
REHAB TO PERFORMANCE
CHIROPRACTIC • PHYSICAL THERAPY

Massage Therapy, Pilates Conditioning & Athletic Training

We want to take this moment to thank you for coming to see us today, welcome you to our clinic and inform you of our policies for services rendered here at SOL Santa Cruz.

Agreement of Release and Waiver of Liability

1. I understand that I am participating in Massage Therapy, The Pilates Method and/ or Athletic Training offered by SOL Santa Cruz during which I will receive information and instruction about Massage Therapy, The Pilates Method and/or Athletic Training. These services are not physical therapy, nor chiropractic, and are for wellness purposes only. I recognize that exercise involves physical exertion which may be strenuous and may cause physical injury, and I am fully aware of the hazards involved.
2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in Massage Therapy, The Pilates Method and/or Athletic Training. I represent and warrant that I am physically fit and have no medical condition which would prevent my full participation in such services.
3. In consideration of being permitted to participate in Massage Therapy, The Pilates Method and/or Athletic Training offered by SOL Santa Cruz, I agree to assume full responsibility for any risks, injuries or damages, known or unknown, that I may incur as a result of participating in the sessions. I knowingly, voluntarily and expressly waive any claim I may have against SOL Santa Cruz for injury or damages that I may sustain as a result of participating in the sessions.
4. I, my heirs, or legal representatives, forever release, waive, discharge and covenant not to sue SOL Santa Cruz and its officers, teachers, and agents for any injury caused by my participation in Massage Therapy, The Pilates Method and/or Athletic Training.

Financial Agreement

5. I understand that Massage Therapy, The Pilates Method and/or Athletic Training sessions offered at SOL Santa Cruz are wellness services, meaning I agree to pay the cash rate and that full payment is due at the time of service. The services I receive will not be billed to my insurance, nor will I receive codes to submit to my insurance for reimbursement. If I choose to pay for a discounted package of sessions, I understand that the sessions do not expire and the purchase is non- refundable.
6. SOL Santa Cruz asks that appointment cancellations be made within 24 hours. If I cancel my Massage Therapy, The Pilates Method and/or Athletic Training session, or miss more than half of my scheduled time, I agree to pay a missed appointment charge of $45.

I have carefully read, fully understand, and voluntarily agree to the policies listed above.

Client Name (Please Print)_____

Client or Guardian Signature_____ Date_____
Guardian Name & Relation(if different than client)_____

Massage Therapy, Pilates Conditioning & Athletic Training
New Patient Information

Date:_____/_____/_____

Full Name_____ **Phone**_____ **Male / Female**

Address_____
City_____**State**_____**Zip**_____

Email Address_____

Date of Birth_____/_____/_____ **How did you hear about us?**_____

Occupation_____ **Emergency Contact**_____**Phone**_____

Accident & Injury History (please list complete history and any permanent problems)

_____
_____
_____
_____

Chronic Illness_____

Have you ever had:

___High Blood Pressure ___Heart Problems ___Joint Problems ___Diabetes ___Whiplash ___Surgery
___ Liver Disease ___ Sprains ___Fractures ___Asthma ___Cancer (type_____)

Please explain:_____
_____

Which of these activities have you participated in?

___Dance ___Yoga ___Martial Arts ___Running ___Swimming ___Aerobics ___Nautilus ___None
Sports(please list)_____
Other (please specify)_____

Are you pregnant? ___Yes ___No **Have you recently given birth?**___Yes ___No (if yes, date_____)

Medications you are now taking_____

Is there anything else that could affect your work with us? Please describe_____
_____

Are you currently receiving care through:

___Physical Therapy (if so) Therapist's Name_____ Phone (if not @ SOL)_____
___ Chiropractic (if so) Doctor's Name_____Phone (if not @ SOL)_____
___ Physician (if so) Doctor's Name_____ Phone_____
___ Massage or other bodywork (if so) Name_____Phone_____