NEOS MASSAGE

Come To Neos & Be Renewed

Policies and Procedures

~ Payment is due in full at time of service
~ Please give 24 hour notice to reschedule/cancel your appointment or $30 no show fee will be billed to you
~ There is a $20 fee for returned or bounced checks
~ Neos reserves the right to refuse treatment if there is an outstanding balance
~ Neos reserves the right to cancel appointments without warning if there have been two no-show's.

Informed Consent

I have read the above information and agree to the terms and conditions outlined in this document. I understand that massage or bodywork is not a substitute for a medical exam or treatment and does not cure my health problems. 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. I understand that there shall be no liability on the practitioner's part should my condition change.

Signature _____

Date _____

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Medical Release

As part of the health care team, Molly Snow, LMT, may be asked to share treatment findings and outcomes with other healthcare providers. Your signature below will give her permission to share pertinent information with your doctor, chiropractor, or other qualified medical specialists.

I, _____ give permission to Molly Snow, LMT and Neos Massage to release any medical information or discuss any of my health related issues with my physicians.

Signature _____

Date

Massage Intake Form - CONFIDENTIAL INFORMATION

Name_____ **Date of birth**_____
E Mail Address_____
Phone_____**Occupation**_____

Have you ever received massage therapy? Yes No
Type of massage experienced (swedish, shiatsu, deep tissue, etc.)
Are you currently taking any medications? Yes No
If yes, please list name and reason for medications

_____
_____

Are you currently seeing a healthcare professional? Yes No
If yes, please list names and reason/treatment

_____
_____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

_____arthritis
_____blood clots
_____bruise easily
_____chronic pain
_____auto-immune condition*
_____skin conditions
_____surgery
_____depression, panic disorder, other psych condition
_____diverticulitis
_____heart conditions
_____high blood pressure
_____muscle strain/sprain
_____scoliosis
_____whiplash
_____diabetes
_____broken/dislocated bones
_____cancer
_____constipation/diarrhea
_____hepatitis (A, B, C, other)
_____stroke
_____TMJ disorder
_____headaches
_____back problems
_____insomnia
_____pregnancy
_____seizures
_____chemical dependency (alcohol, drugs)

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs detailed or if there is anything else to share, please do so

_____
_____

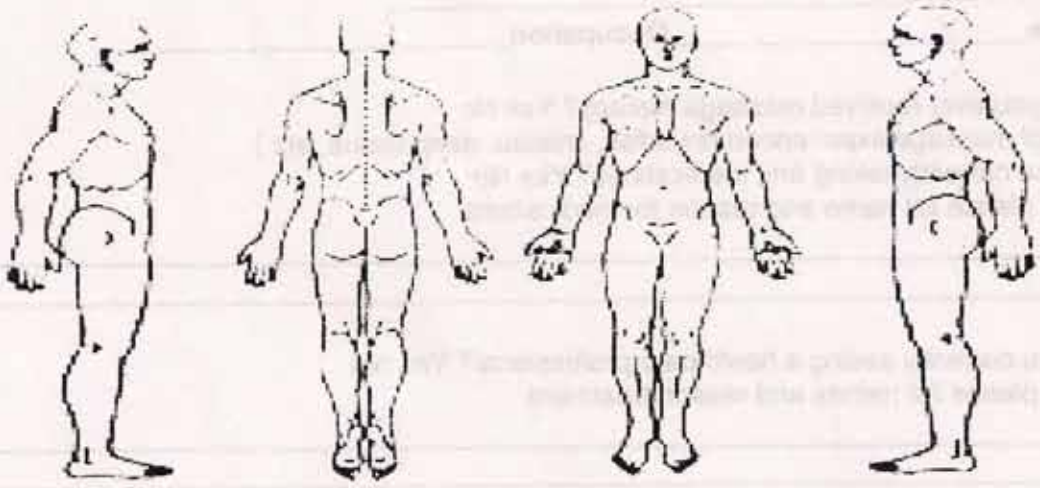
Do you have any of the following today:

_____skin rash _____cold/flu _____open cuts _____severe pain
_____anything contagious _____injuries/bruises

Do you have any allergies to _____fragrances _____skin care products
If any of the above are checked, please give details:_____

Are you wearing: _____contact lenses _____hearing aid _____hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session?

Guest's signature_____ Date_____

This section for Therapist's use only

Additional comments: