

SMOOTH SYNERGY

(212) 397-0111

MASSAGE CONSENT FORM

Name: _____ Date: _____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip Code: _____
Home phone: _____ work phone: _____ cell phone: _____
E-mail: _____
May we call to confirm your appts.? Yes No
Referred by: _____ Occupation: _____

Medical History

1. Do you have any of the following pre-existing medical conditions?

- Vascular Problems
- Phlebitis
- Diabetes
- Surgery/Implants
- Osteoporosis
- Arthritis
- Skin conditions
- Cancer
- Pregnancy
- HIV/AIDS
- Scoliosis
- TMJ
- Neurological Disorders
- Multiple Sclerosis
- Other (please specify)
- High Blood Pressure
- Immune Disorder

2. Have you suffered or do you now suffer from any pain?
If so, where?

3. Do you experience dizzy spells / fainting?

4. Are there any areas that need to be avoided?
If yes, please specify:

5. Have you received any bodywork before?

6. Are you currently taking any medications (over-the-counter, prescription, oral, topical, etc.)?

If so, what kind, when was the last dose, and/or where was it applied?

7. Do you have any allergies (to medication, foods, etc.)?

8. Have you consumed any alcohol within the last 12 hours?

What would you like to get out of this treatment?

I hereby certify that the following information is true and accurate to the best of my knowledge. In case of intentionally misleading answers the physician and /or technician can not be held responsible for any future outcome.

I have been fully informed about the procedure and have had ample opportunity to ask questions concerning the treatment. I fully consent to the treatment and agree to hold Smooth Synergy, LLC and any and all parties affiliated herewith, harmless and free from any and all liability that may arise as a result of this treatment both now and in the future.

Print Name _____

Signature _____ Date _____



MESSAGE CANCELLATION POLICY

Client acknowledges and accepts full responsibility & guarantees full payment for all services rendered. Member agrees that Smooth Synergy may pursue all avenues of collection including use of collection agencies and authorizes Smooth Synergy to prepare and submit credit card charges using the credit card listed below to recover charges and all other unpaid amounts. If Smooth Synergy retains the services of a collection agency or attorney to effect collection, Client will promptly reimburse Smooth Synergy for all of Smooth Synergy's reasonable and necessary attorney's fees and disbursements incurred in connection herewith.

Smooth Synergy shall also not be obligated to reimburse client for any monies that were pre-paid for treatments. It shall instead apply any unused funds towards future treatments.

Any prepaid services not used within one year of purchase shall expire and no longer be valid.

I also understand that failure to provide 24 hours notice of cancellation will result in the charge of 100% of the services scheduled, which will automatically be charged to my credit card.

Credit Card Name & Number: _____

Exp. Date _____ Security Code: _____ Billing Zip Code: _____

Patient name (print): _____

Date: _____

Signature: _____

****Please note: WE DO NOT ACCEPT CHECKS**