



**Massage Therapy & Pilates Conditioning**  
**Office Policies**

We want to take this moment to thank you for coming to see us today, and welcome you to our clinic! We would also like to inform you of our policies, and we appreciate your reading the following information about Massage Therapy and/or The Pilates Method.

Please ask our staff if you have any questions.

**Agreement of Release and Waiver of Liability**

1. I understand that I am participating in Massage Therapy and/ or The Pilates Method offered by SÖL Santa Cruz during which I will receive information and instruction about Massage Therapy and/ or The Pilates Method. 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 and/or The Pilates Method. I represent and warrant that I am physically fit and have no medical condition which would prevent my full participation in Massage Therapy and/or The Pilates Method.
3. In consideration of being permitted to participate in Massage Therapy and/or The Pilates Method offered by SÖL 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 SÖL 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 SÖL Santa Cruz and its officers, teachers, and agents for any injury caused by my participation in Massage Therapy and/or The Pilates Method.

**Financial Agreement**

5. I understand that Massage Therapy and/or The Pilates Method sessions offered at SÖL 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. SÖL Santa Cruz asks that appointment cancellations be made within 24 hours. If I cancel my Massage Therapy and/or The Pilates Method session, or do not show up within 15 minutes of my scheduled time, I agree to pay a charge of \$45.

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

Patient Name (Please Print) \_\_\_\_\_ Guardian/Parent \_\_\_\_\_

Patient Signature \_\_\_\_\_ Guardian/Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

**Massage Therapy & Pilates Conditioning**

**New Patient Information**

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Full Name \_\_\_\_\_ Phone \_\_\_\_\_ Male / Female

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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 \_\_\_\_\_

**Which therapist or instructor will you be seeing today?**

\_\_\_ Jean Bathke (Massage) \_\_\_ Debra Smith (Massage) \_\_\_ Shari Scruton (Pilates)

## SÕL SANTA CRUZ DISCLOSURE FORM

Welcome to SÕL Santa Cruz, located at 1510 Seabright Avenue, Santa Cruz, California 95062.  
For my treatment, I am seeking the following:

*Please initial on the appropriate line below:*

\_\_\_\_\_ Chiropractic services provided by Karen K. Roitz, D.C., C.C.S.P.

\_\_\_\_\_ Physical Therapy services provided by Sports and Orthopedic Leaders Physical Therapy, Inc.  
(SÕL PT)

\_\_\_\_\_ Massage Therapy services

\_\_\_\_\_ Pilates Fitness services

By signing below, I hereby acknowledge and understand that SÕL Santa Cruz: (a) is the trade name under which various independent medical practitioners and professionals market their services and share office space; (b) does not provide any patient or other services; and (c) is not a group practice or partnership. All of the services offered at this location are provided by independent licensed practitioners or professionals, who will each require my individual consent prior to providing treatment or providing services, and who are solely responsible for my treatment or well being while at this facility. I further acknowledge and understand that should I require treatment by more than one named individual or entity above, I will be required to sign separate agreement and consent forms with such individual or entity prior to treatment. No other practitioners or professionals shall be responsible for my care or well being – even if such treatments or services are provided in the shared SÕL Santa Cruz facility.

Please  
initial  
here

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature