La Bonne Vie Massage **Intake Form**

Provider:_____
ID:_____
Group:_____

Please tell me about yourself

Last Name _____ First Name _____ Middle Initial ____

Date of Birth _____ (Y / M / D) Occupation _____

Address _____

City_____ Postal Code _____ Email _____

Phone numbers _____

Emergency Contact _____

How did you hear about this clinic?_____

What brings you in today?_____

_____

_____

Cancellation Policy

Payment is expected in full, when services are rendered. If you are unable to keep your appointment, please notify the clinic at least 24 hours in advance. Please be aware that any appointments canceled with less than 24 hours notice will result in a **$30 missed appointment fee**.

Privacy Policy

The personal Information collected will not be shared with other clinics or practitioners, without your written consent.

Consent

I understand that I am responsible for all charges related to my visit. I understand that there may be risks involved in receiving massage treatment, and have consulted with my physician, who has approved massage as an acceptable and safe modality for me. I will inform my massage therapist of any discomfort or concerns I have before, during or after my treatment.

Today's Date _____ Signature _____