Oasis Massage

Contact & General Information

Client Name: ________________________________ DOB:_________ Occupation: _______________________
Address: ____
Phone: _______________________________ Email: _____________________________________
How would you like to receive appointment confirmations? ☐ Email ☐ Text/SMS ☐ Both
☐ Check here if you do not want to be added to our mailing list.
Emergency contact: ______________________________ Phone: __________________________________
Referred by: _____________________________________ Phone: __________________________________
Were you referred by a doctor or will you be seeking reimbursement from an insurance company?
☐ Yes ☐ No If yes, a physician's prescription will be required.

Company Policies

Cancellation Policy: All appointments are carefully timed. To avoid paying for missed appointments, a cancellation notice of 24 hours is required for all clients. Exceptions may be made to this policy for emergency situations; please speak with the Office Manager to discuss your situation. Please note that work conflicts are not considered emergencies.

Late arrivals: Clients will receive the time remaining on their scheduled service and will be charged for the full amount, regardless of actual length of service received. Clients that opt to reschedule will be charged a Late Cancellation Fee.

Missed Appointment Fee: Clients will be charged 100% of their scheduled appointment fee if they show up sick or are a No-Call, No-Show.

Late Cancellation Fee: Clients will be charged 50% of their scheduled appointment fee if they cancel or reschedule with less than 24 hours notice.

Inappropriate Behavior: Any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Outstanding Balance Policy: All fees and/or unpaid services must be paid in full prior to scheduling future services. For balances related to insurance billing, a payment plan may be implemented while continuing to complete the prescription. Payment plans will be set up on a case-by-case basis with client's budget in mind.

Refund Policies

- No refunds will be issued once a service has been provided.
- Refunds for a series (or membership, if terminated early) will be pro-rated to the regular rate before a refund is issued for remaining balance.
- Retail items may be returned unused within 30 days for a full refund; receipt required.
- To reverse a charge to a credit card, the entire transaction must be refunded. All refunds for partial transactions will be issued by check.
- Refunds of cancellation fees or missed appointment fees require manager approval.

I acknowledge and agree to the above policies.

Signature: ____ **Date:** ____________

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COVID-19 Information & Consent

________(Initial) **INFORMED CONSENT** I understand that COVID-19 is transmitted through close contact with others and that people without symptoms may be infectious. I know the longer I am exposed to someone with COVID-19, the easier it is to spread. I understand that because massage therapy work involves maintained touch and close proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. I understand that this massage business has taken every precaution to ensure my health and safety, but that risk of infection is still possible. By signing this form, I acknowledge that I am aware of the risks involved in receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner and Oasis Massage from any claims related thereto. I give my consent to receive treatment from the practitioners at Oasis Massage.

HEALTH CONDITIONS THAT INCREASE RISK OF SERIOUS COVID-19 INFECTION

People 65 years or older	Chronic lung diseases	Cardiovascular conditions
Suppressed immunity (e.g., medication)	Moderate to severe asthma	Severe obesity (BMI 30 or higher)
Compromised immunity	Chronic kidney diseases	Diabetes
Liver diseases	Smoking	Pregnancy

________(Initial) **HIGH-RISK AWARENESS** I understand that the health conditions listed in this document above place me at higher risk for serious COVID-19 infection. Should I decide to proceed with massage therapy I assume all risks related to COVID-19 infection.

________ (Initial) **DEPARTMENT OF HEALTH AND EXPOSURE TO COVID-19** I understand that if a client, therapist, or staff member of this facility tests positive for COVID-19 within a time frame that places me at risk of exposure, my name, and contact information will be shared with the State Department of Health for their follow-up. If I develop symptoms of illness within two weeks of my massage appointment; I will contact this massage facility immediately and notify them.

By signing below, I have read, or have had read to me, the COVID-19 information and give my consent to receive massage therapy at this facility.

Client Signature: ______________________________________ Date:_________