MOUNTAIN LAUREL
PILATES

Client Waiver of Liability/Informed Consent

I hereby affirm that I am in sound physical condition and able to participate in a physical exercise program which may be rigorous at times. I recognize that participation in these programs of exercise is voluntary on my part, and that there are inherent risks, which I hereby assume for myself, my heirs, and assigns. I recognize that many changes may occur as a result of these exercise sessions, including possible short term aggravation of some symptoms: feelings of lightheadedness, increased energy, mood changes, etc. Mountain Laurel Pilates LLC, and/or Judy, and/or Mountain Laurel Pilates Staff, and/or Independent Contractors shall not be liable for any injuries or damages to any participant, or the property of any participant, or be subject to resulting from acts of negligence for the part of the Mountain Laurel Pilates, Judy Fink, and/or Independent Contractors. In consideration of my acceptance as a participant in such activities, I expressly waive, release and discharge Mountain Laurel Pilates, Judy Fink, Independent Contractors, officers, directors, employees, substitutes, agents and successors, from any obligations, liabilities, claims, demands, costs, and expenses, including attorney fees, arising out of, or in connection with, any bodily injury however caused, occurring during or after my participation in the exercise program, workshops, and certification programs. *(Initials)* _____

Policies Statement

1. **Refund Policy There are no refunds or credits to credit cards. Accounts are not transferrable.** If a physician has determined that there are medical reasons that you cannot complete your package, we will refund the unused portion of your package minus a $10 administrative fee. A written explanation from your physician is required in order to process your refund request. There are NO exceptions to this!
2. **No refunds on Gift Certificates.** *(Initials)* _____

Last Name _____ First Name _____ Home Phone _____

Home Address _____ Cell Phone & Cell Phone Provider* _____

City _____ State / Zip / Country _____ Work Phone _____

Date of Birth _____ Email _____ How did you hear about us? _____

I hereby affirm that I have read, fully understand, and accept the above.

Participant's Signature _____ Date _____

*By providing your cell phone provider, you agree to receive text messages about your upcoming appointments and classes.

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Client Medical History

Name _____ Date _____

Do you now, or have you ever been treated for any of the following conditions:
(circle and explain where applicable)

ARTHRITIS	DIABETES	LUNG PROBLEMS
CHRONIC ILLNESS	LIGHTHEADED/DIZZY	SEIZERS
OSTEOPOROSIS	EATING DISORDERS	STROKE / HEART ATTACK /
SMOKER	HIGH BLOOD PRESSURE	HEART DISEASE

ORTHOPEDIC PROBLEMS: (CIRCLE) BACK / FEET / KNEE / JOINT / OTHER

Please explain any conditions circle above:

_____

List Medications:

_____

List any Accidents or Injuries (falls, auto, athletic, childhood, etc):

_____

Surgeries & Dates:

_____

Have you been released to exercise? YES NO (please circle one)

List Medical Professionals you are currently seeing for chronic problems. Include family practitioner, osteopaths, chiropractors, massage therapists, etc:

_____

May we phone them to discuss your exercise program? YES or NO (circle one)

Emergency Contact Information:

_____ _____
Name Phone

Cancellation Policy:

- No shows and cancellations less than 24hrs will be charged a full session fee. This applies to individual sessions, duo sessions, trio sessions, and mat classes.
- Please make changes to your schedule at least 24hrs in advance to allow the time slot to be filled.

I have read and agree to the above policy conditions.

_____ _____
Signature Date