Client Release Form

1. I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist if any physical discomfort or draping issues occur during any session.

2. Absolutely no unprofessional behavior will be tolerated. Sexual advances will result in immediate termination of service and full payment will still be expected.

3. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.

4. It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body after cupping.

5. I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be cleared away by my circulatory system.

6. I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities. Drinking water will help these marks diminish.

7. I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 4 - 6 hours after treatment. I understand that exposure to such extremes can produce undesirable effects and I should avoid such situations.

8. I understand any stretches or exercises shown after treatment is suggested and I should contact Body Fountain if I have any questions or concerns regarding the exercises.

9. We do require a 24 hour cancellation notice to prevent being charged a late cancellation fee of 50% of the service price. No show appointments will be charged 100% of the service price.

I _____ agree to allow the Licensed Practitioner to perform therapy. I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner or Body Fountain Ltd. responsible.

Date_____ Signature of Client _____

Print Name _____

Date_____ Signature of Practitioner _____

Print Name _____