



Client Contact Information/ Liability Agreement (Yoga Therapist in Training)

(ALL INFORMATION GATHERED ON THIS FORM IS CONFIDENTIAL)

PERSONAL INFORMATION:

Name: _____

Sex/ Gender/ Pronouns: _____

DOB: _____ Age: _____

Address: _____

Home Number: _____ Cell Number: _____

Email: _____

I would like to receive regular updates regarding threeOMs Yoga Therapy via email.

EMERGENCY CONTACTS:

Primary Health Care Provider's (PHCP) Name: _____

PHCP's Contact Number: _____

Next of Kin #1 (NOK): _____ Relationship: _____

NOK #1 Contact Number(s): _____

NOK #2: _____ Relationship: _____

NOK #2 Contact Number(s): _____

Other Health Care Provider Contacts: (client consent will be obtained prior to contacting the below HCP's)

Psychologist, Psychiatrist, etc.	
Massage Therapist, etc.	
Chiropractor, Physiotherapist, etc.	
Registered Dietitian	
Medical Specialist (Oncologist, Cardiologist, OB/GYN, etc.)	
Other:	

SOURCE OF REFERRAL:

How did you find out about threeOMs Yoga Therapy: _____

CURRENT/ PREVIOUS EMPLOYMENT: NOT APPLICABLE

Current/Previous Employment Title: _____

Company/Organization: _____

Length of Employment: _____

Reason for Leaving (if applicable): _____

Other Career/Employment Information: _____

MOST CURRENT/ SIGNIFICANT EDUCATION/STUDIES: NOT APPLICABLE

Area of Studies: _____

Educational Institution: _____

Length of Studies: _____

Other Education/Studies Information: _____

GENERAL MEDICAL/HEALTH INFORMATION:

Reason(s) for seeking the help of a Yoga Therapist?	
General health issues (diagnoses, surgeries, accidents, injuries, etc.)?	
Medical care currently receiving from above health issues?	
Medications/ supplements currently taking?	
Accessibility needs required for Yoga Therapy sessions?	
Any other important information regarding your health/ medical status?	

FORMAT & AVAILABILITY FOR YOGA THERAPY: *(circle all that may apply)** I am interested in: **PRIVATE SESSIONS** **SMALL THERAPEUTIC GROUP CLASSES*** I prefer: **IN PERSON** **ONLINE (Zoom, Google Meet, etc.)**

* My typical availability for Yoga Therapy sessions:

DAYS of WEEK: _____

TIME of DAY: _____

* I would like to receive appointment reminders: **NO** **YES** *(if YES, VIA: TEXT PHONE EMAIL)*

LIABILITY WAIVER: Please read the following statements and initial when in agreement.

- _____ I understand that the yoga therapist is currently in training and practicing under supervision/consultation with faculty at the Yoga Therapy Institute.
- _____ I understand that any personal/medical information I provide the yoga therapist may be shared with the supervising faculty of The Yoga Therapy Institute for educational purposes only.
- _____ I understand that yoga therapy and the care provided by the yoga therapist is not a replacement for medical care nor can the yoga therapist provide me with any medical diagnosis or prognosis.
- _____ I understand that the yoga therapist relies on the information provided by me to facilitate a safe and comfortable practice. I understand that I am responsible for informing the yoga therapist when a pose or practice causes me discomfort of any kind (physical, emotional, etc.) as well as notifying the yoga therapist of any new or recurring physical or emotional condition/ injury that may negatively affect my current practice/session of yoga therapy.
- _____ I understand that my personal information will be kept in a secure database that adheres to sound privacy and confidentiality practices.

IMPORTANT THINGS TO KNOW: Please read the following statements and initial when in agreement.

- _____ I have read through the threeOMS Yoga Therapy Important Things to Know! document.
- _____ I agree with the COMMUNICATION policies and procedures.
- **Client Contact Preference(s): _____
- **Yoga Therapist Contact Preferences: phone (text, call, voice message) or email via the contact info provided
- _____ I agree with the CONFIDENTIALITY policies and procedures.
- _____ I agree with the FORMAT/ LOCATION OF SESSIONS policies and procedures.
- _____ I agree with the CASE STUDY PRICING & PAYMENT policies and procedures.
- _____ I agree with the CANCELLATION/ NO SHOWS policies and procedures.
- _____ I agree with the STORAGE/ DESTRUCTION OF PERSONAL HEALTH INFORMATION policies and procedures.
- _____ I agree with the PHYSICAL TOUCH policies and procedures.
- _____ I agree with the PROFESSIONAL CONSULTATION policies and procedures.
- _____ I agree with the MARKETING COMMUNICATIONS policies and procedures.
- _____ I agree with the RIGHT OF REFUSAL policies and procedures.

Clients will be notified of any changes in policies and procedures as soon as it is possible.

"I have read the above agreement and fully understand its contents. (If I do not understand items in the above agreement, I have asked for and received satisfactory clarification prior to signing.)

By signing below, I agree to all the above statements."

Client signature: _____

Yoga Therapist signature: _____

Date: _____

Client copy of signed agreement requested? YES NO

