Client Contact Information/ Liability Agreement

(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 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 if I have any medical condition(s) or a health status that requires prior approval by my primary health care provider, that I have already obtained clearance by that individual. I also affirm that I alone am ultimately responsible to decide whether to practice yoga and participate at my own risk. Because of that, I release threeOMs Yoga Therapy from any grievances or claims of ill harm as a result of practicing yoga.*

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 COMMUNCIATION 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 PRICING & PAYMENT policies and procedures.*

_____ *I agree with the CANCELLATION/ NO SHOWS policies and procedures.*

_____ *I agree with the PHYSICAL TOUCH policies and procedures.*

_____ *I agree with the STORAGE/ DESTRUCTION OF PERSONAL HEALTH INFORMATION policies and procedures.*

_____ *I agree with the PROFESSIONAL CONSULTATION policies and procedures.*

_____ *I agree with the MARKETING COMMUNCIATIONS 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*