

**Please read and sign the following statement regarding our cancellation policy:**

As we value each client and want to establish a caring and beneficial relationship with you, we ask that you respectfully value your time with us here as well. We understand that unanticipated events happen occasionally in everyone’s life and in our desire to be effective and fair to all clients, the following policies are honored:

Due to habitual missed appointments, there may be a missed appointment fee charged to you, the client. We regret any inconvenience but missed appointments and cancellations not given **24-hours in advance have caused an inconvenience for our staff, as well as another client that could be scheduled at that time.** If you are unable to give us 24-hours advance notice, you will be charged **a flat rate of $30**. This amount must be paid prior to your next scheduled appointment. A credit card will be required to place on file when scheduling an appointment over the phone to hold the appointment.   
  
**In the event of a no-show,** anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a “no-show.” They will be charged **a flat rate of $30** for their “missed” appointment as well.

Thank you for your cooperation.

Print Name

Signature Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CUPPING RELEASE STATEMENT**

*I understand that all treatments at this facility are therapeutic in nature. I agree to notify the therapist of any physical discomfort or draping issues during the session.*

*This facility has provided me with information on Massage/MediCupping™ therapy. If I choose to experience this therapy in my treatment, I understand the effects and after-care recommendations. It has been explained to me that there is the possibility of a skin discoloration, or “cup kiss”, appearing as tissue is released. I am aware that a “cup kiss” is not a bruise and that it will dissipate within a few hours to a few days.*

*This facility and the therapist will not be held liable for indications that arise during or after the treatment, and I agree to notify the therapist if there is any discomfort during a session. I have stated all relevant physical conditions and will inform the therapist of any changes in my health.*

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_