Practitioner Name: Leslie Cotham, CMT
Contact Information: 805-235-6297
leslie@energy-in-motion.net

ENERGY IN MOTION
WELLNESS

Office Policies

Client Information

Client Name: _____ Date: _____ Date of Birth: _____

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellations

Amid the ongoing uncertainty of COVID-19, I have modified my cancellation policy to offer greater flexibility to all clients. I hope this will alleviate any stress and hesitation you have about an upcoming appointment. If you need to reschedule for whatever reason, and especially if you are not feeling well, I understand and request for you to please contact me as soon as possible to reschedule. To further support you, there will be no penalties for cancellations at this time.

Late Policy

Appointment times are as scheduled, and for the moment, I will not be able to extend beyond the stated time to accommodate late arrivals. It's important that I have enough time to clean the office between each client. Please make sure you are able to be on time for your appointment in order to get your full treatment.

Sickness

Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee will be waived.

Email List

Your signature below indicates that you give permission to be added to my email list. The email list is used to send out policy updates, annual specials and last minute appointment openings.

If you **DO NOT** wish to be added, please indicate below. If you do wish to be added, please give me the email that works best for you.

____**DO NOT** add me to the email list. **EMAIL:**_____

Financial Responsibility

Your signature below confirms your financial responsibility for all services.

Release of Medical Records

Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature: _____ Date: _____