



www.dancingmoonpilates.com | 704-641-0455
15905 Brookway Drive Suite 4210, Huntersville, NC 28078

Client Information and Policy Form

Client Information

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME#: _____ CELL#: _____

EMAIL: _____

DATE of BIRTH: _____ OCCUPATION: _____

How did you hear about us? _____

Who referred you? _____

Emergency Contact Info

NAME: _____

PHONE#: _____ RELATIONSHIP: _____

Health History - Please circle all that apply:

Scoliosis	Fused disks	Herniated disks	Osteoporosis	Back surgery	Asthma
Sciatica	Arthritis	Plantar Fascitis	Stress	Low Flexibility	
Migraines	Glaucoma	Hi/low blood pressure	Diabetes	Rheumatoid Arthritis	

Any surgery in last 12 months (requires letter of consent from physician): _____

Other Ailments/Medications: _____

Are you pregnant or planning a pregnancy? _____ How many weeks (requires letter of consent from physician)? _____

Studio Booking and Payment Policies

- I understand that all appointments are subject to a 24-hour cancellation policy, and that if I fail to cancel within 24 hours my account will be charged with the full amount.
- There are no refunds or transfers of packages.
- All packages expire automatically 3 months after the date of purchase.
- There is a \$35 fee for all returned and bounced checks.

SIGNATURE: _____ DATE: _____



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Liability Release Form

I _____, voluntarily consent to participate in an exercise program and/or assessment with Dancing Moon Pilates, LLC. I recognize that these activities may at times be strenuous. I have been advised and understand that participating in any exercise or conditioning program presents some unavoidable risk of injury, especially to people who have pre-existing injuries, illness or medical disabilities.

I understand that a medical evaluation is advisable before commencing any exercise or conditioning program. By my participation in any of these activities, I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate without the approval of my physician. I understand that in rare cases physical exercise can cause dizziness, chest discomfort, nausea, and joint or muscle soreness.

I assume all risks involved and hereby waive, release and forever discharge Dancing Moon Pilates, LLC, its members, officers, employees and staff from any and all claims, suits, losses or causes of action for damages, injury, disability or death, including claims for negligence, arising out of or related to my participation in any Dancing Moon Pilates, LLC exercise program or assessment.

I have read and understand this informed consent and release of liability and it accurately sets forth my intentions and, I agree to be bound by its provisions.

PRINT NAME: _____

SIGNATURE: _____

DATE SIGNED: _____

