

Alison Lively, ND



Alicia Bliss, ND, RYT

700 E North St, Unit 5, Greenville SC 29601 (864) 313-8812
info@creativelivingwellness.com www.creativelivingwellness.com

Yoga Release and Waiver of Liability

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Limitations, Injuries, Surgeries: _____

If So, Date of Onset or Surgery: _____

Emergency Contact: _____

In any physical activity, risk of serious physical injury is possible. Yoga is no substitute for medical diagnosis and treatment. Yoga practice and/or specific poses are not recommended for individuals with certain conditions (e.g., cardiac illness, later stages of pregnancy, post-surgery). The student assumes the risk of yoga practice and release the teacher(s) and Creative Living Wellness from any liability claims.

I, _____, am participating in yoga classes, or workshops, at Creative Living Wellness. I am aware of the physical risks involved with strenuous exercise and understand it is my personal responsibility to consult with my doctor regarding my participation. I have no medical condition which would prevent me from taking part in yoga classes or workshops, and I assume responsibility for any risk or injury I may sustain as a result of my participation.

I acknowledge that my signature indicates that I have read, understand, and agree with all the above statements.

Signature: _____ Date: _____

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Cancellation & No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you **provide at least 24 hours notice**. This will enable us to schedule another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other clients.

Appointments which are cancelled with less than 24 hours notification may be subject to a \$50.00 cancellation fee.

Clients who do not show up for their scheduled appointment without a call to cancel will be considered a **NO SHOW**. Clients who No Show two (2) or more times within a 12 month period will be required to pre-pay for any future appointments.

The Cancellation and No Show fees are the sole responsibility of the client and must be paid in full before the client's next appointment.

Our practice firmly believes that good practitioner/client relationships are based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department at (864) 313-8812.

Please sign to confirm that you have read, understand, and agree to this Cancellation and No Show Policy.

Client Name: _____ Date: _____

Signature of Client or Client Representative: _____