



w e l l n e s s

## Establishing Your Connection

Welcome to **RnR. Wellness**. We invite you to share a few details so our wellness experts may personalize a treatment as unique as you are.

### I. The Guest Registry

Full Legal Name: \_\_\_\_\_

Date of Birth: **m**/\_\_\_\_**d**/\_\_\_\_**y**/\_\_\_\_\_ (to celebrate your wellness milestones)

The Best Number to Reach You: \_\_\_\_\_

Email for Your Journey: \_\_\_\_\_

Billing Address: \_\_\_\_\_

**Who may we thank for recommending us?** \_\_\_\_\_

### II. Lifestyle & Intention

**Daily Activity:**  Primarily Desk-bound  Travel-heavy  Frequently Active  On your feet

**Desired State:**  Grounded  Restored  Awakened  Still

**Pregnancy:** Is there a possibility you are pregnant?  No  Yes: \_\_\_\_\_ Weeks

### III. Esthetic & Skin Therapy **I am Not receiving an Esthetic/Skin service today**

**Skin Concerns** (Check all that apply if having this service):

Oily / Large Pores  Acne / Breakouts  Dry / Dehydrated  Flaky / Tight

Rosacea / Redness  Fine Lines / Aging  Pigmentation / Sun Damage  Loss of Elasticity

**Current Products & Clinical History:** (Check all that apply if having this service):

Retin-A / Renova / Tretinoin  Accutane (In the last 6 months)  Glycolic / Salicylic / AHAs

Vitamin C  Hydroquinone / Lighteners  Topical Antibiotics Steroids / Hydrocortisone

Recently Tanned (Sun/Bed/Spray)  Recent Waxing / Threading  Eyelash Extensions

Wearing Contact Lenses  Botox / Fillers (Last 14 days)  Nut / Shellfish Allergies

Chemical Peel / Laser (Last 14 days)

To understand your skin's history, please check all daily home care rituals that applies:  Cleanser

Toner  Serum  Eye Cream  Moisturizer  Exfoliant/Mask  SPF  Other products

IV. Massage & Body Therapy (RMT)  *I am Not receiving a Massage/Body service today*

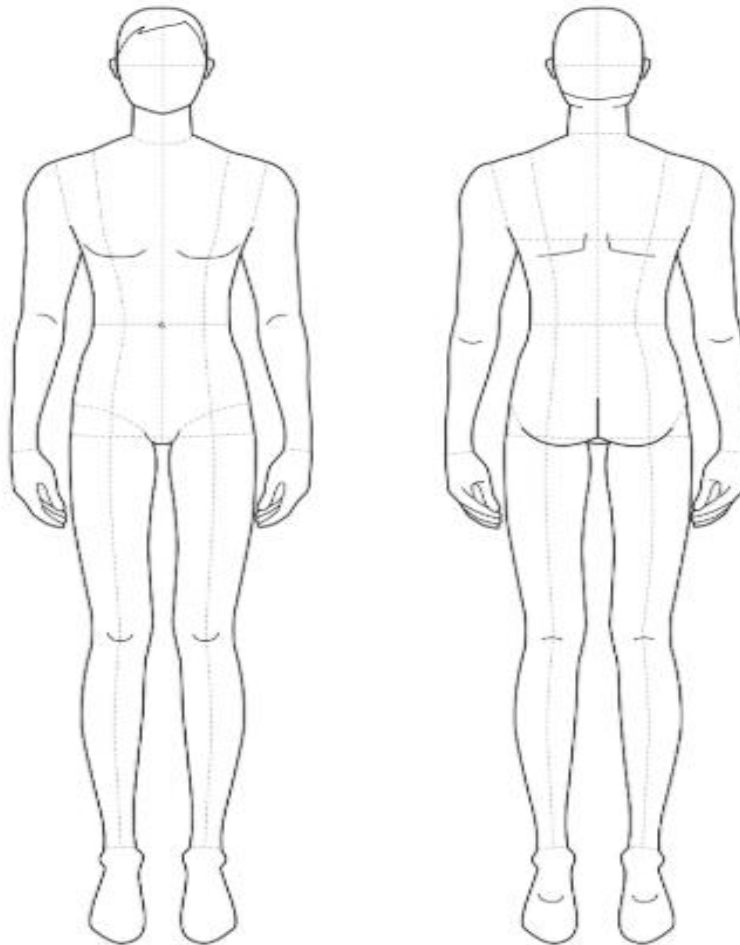
Focus Areas: \_\_\_\_\_ Pressure:  Light  Med  Firm

Scent:  Invigorating  Calming  Scent-Free

Atmosphere:  Silent Sanctuary  Light Connection  Guided/Educational

### Clinical Mapping & Discomfort

\* Please indicate with an X on the areas of tension, pain, or discomfort on the diagrams below:



### Consent to Treat Sensitive Areas

For clinical efficacy, some treatments require work on sensitive regions. I specifically consent to have the following areas treated when clinically indicated:

Gluteal Region (**Buttocks**)  Upper Inner Thighs  Chest Wall (**Pectorals**)  Abdominal Area

**V. Universal Health History \* (Required for All Guests for All Treatments)**

*\* Please select any conditions that apply to you so we may ensure your safety*

<b>Systemic &amp; Internal</b>	<b>Musculoskeletal</b>	<b>Respiratory &amp; Wellness</b>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Recent Surgery	<input type="checkbox"/> Asthma
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Recent Injuries	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Metal Implants/Pins	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Blood Clots / Phlebitis	<input type="checkbox"/> Neck / Spine / Disc Injury	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Heart Disease / Pacemaker	<input type="checkbox"/> Osteoporosis / Arthritis	<input type="checkbox"/> Gastro-intestinal Ailments
<input type="checkbox"/> Diabetes (Type I or II)	<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Skin Sensitivities / Allergies
<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Joint Pain / Stiffness	<input type="checkbox"/> Rosacea
<input type="checkbox"/> Cancer / Remission	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Eczema / Psoriasis
<input type="checkbox"/> Anxiety / Depression	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Active Cold Sores / Warts
<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Infestations ( Athlete's Foot)

**VI. The Sanctuary Agreement**

**The Atmosphere**

**Silence:** Devices silenced. | **Respect:** Zero-tolerance for inappropriate behavior. (verbal or physical)

**Sobriety:** No alcohol or other substances. | **Valuables:** The spa is not liable for lost/stolen items.

**Commit to the Atmosphere**

## VII. The Sanctuary Agreement | *continued*

**The Schedule: 24-Hour Notice:** Required for all adjustments. | **Timing:** Changes within 24 hours or late arrivals incur full-service fees.  **I Commit to the Schedule**

### The Care & Professional Boundaries:

**Clinical Scope:** Our therapies are for wellness and restoration; they do not replace medical diagnosis.

**Mutual Respect:** We provide a professional sanctuary. Inappropriate conduct will result in the immediate conclusion of the session at the full-service fee.

**Privacy & Draping:** We honor your comfort with professional clinical draping and protect your personal data under Alberta PIPA guidelines.

**Release:** I assume all risks and release **RnR Wellness** from liability regarding undisclosed health conditions.

**Guest Agency:** This is your journey. You are encouraged to request adjustments to pressure, temperature, or scent at any time.  **I Honor the Care & Boundaries**

## VIII. E-Claims Authorization

### Insurance Provider Details

**Primary Insurer:** \_\_\_\_\_ **Plan Member Name:** \_\_\_\_\_

**Relationship to Guest:** : \_\_\_\_\_ **Member/Policy ID:** \_\_\_\_\_

**Group and ID Number:** \_\_\_\_\_ **Plan Member D.O.B:** m/\_\_\_\_ d/\_\_\_\_ yr/\_\_\_\_\_

**Billing Consent:** I hereby authorize **RnR Wellness** to submit claims electronically to my insurer on my behalf and to collect payment directly. I understand that I am responsible for any co-payments, deductibles, or balances not covered by my plan, payable at the time of service.

**Authorize Direct Billing & Collection**

### VIII. Affirmation of Health & Truth

**Best of my Knowledge:** I certify that the medical history provided is accurate and complete to the best of my knowledge. I acknowledge that undisclosed health conditions may pose a risk to my safety during treatment.

**Ongoing Disclosure:** I agree to update my wellness expert on any changes to my health, medications, or physical condition at the commencement of every session.

**Assumption of Risk:** I understand the nature of the services and assume all risks associated with my treatment based on the information disclosed herein.

**Affirm My Health Information**

**Emergency Contact & Phone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_