

**CONSENT FORM**

I, \_\_\_\_\_, understand that TSW classes, activities and workshops (as defined below) are provided by Third Space Wellness, LLC (“TSW”) staff and/or affiliated teachers. I understand that this agreement covers the Teacher who teaches me and any Teachers associated with TSW who may provide my classes and instruction in the future.

***I hereby give my consent to participate in the following at TSW:***

**Yoga, Movement & Fitness Classes, Activities and Workshops**

Yoga, movement and fitness activities at Third Space Wellness include the physical practice of instructed poses, forms or movements with optional touching or positioning of the body by the teacher.

*Some of our classes and teachers incorporate movement philosophies and practices such as Pilates, kickboxing, dance, breathing techniques, non-combat martial arts forms like Tai Chi or Qi Gong, and/or meditation. All of our teachers are required to possess formal training in any style of movement or practice that they build into their classes and sequences. Please be sure to familiarize yourself with the class description to ensure that the class you are taking is right for you.*

**Request to not be assisted:** If I do not wish to be touched, I will initial here to notify the Teacher, so that a joint decision can be made about where it is appropriate to continue the practice with that limitation (\_\_\_\_\_).

**Potential Risks:** I understand that, while not common, side effects can potentially occur from movement classes. Some examples include, but are not limited to: acute muscle and/or joint pain, pulled muscles, brief changes in blood pressure, lightheadedness and/or dizziness which could cause slip and fall, delayed onset muscle soreness, more chronic conditions such as tendonitis, and other discomforts.

**Medical Treatment:** Our teachers are not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician’s care, I should continue as long as my physician and I deem it necessary. It is my responsibility to consult with my physician before altering any prescribed medications or treatments. I understand also that if there is an emergency, or a worsening of my health condition, or if a new condition arises, that I should consult a licensed physician.

**Voluntary:** I hereby request and consent to participate in yoga, fitness, and movement classes, activities and workshops and/or private yoga sessions. I have not been guaranteed any specific outcomes concerning the uses and effects of any TSW classes, activities, workshops or sessions. I understand that I am free to discontinue my participation in TSW classes, activities, workshops, or sessions at any time. I voluntarily assume all risks inherent in the nature of each of the TSW classes, activities, workshops or sessions. I waive all claims, costs, liabilities, expenses and judgments against TSW and release TSW and its members, officers, agents, representatives, and employees from all claims, costs, liabilities, expenses, and judgments arising out of the TSW class, activity or workshop or session.

**In-home visits:** I understand that TSW is not responsible for “slip and fall” circumstances when providing in-home services, and thus I am responsible for “slip and fall” circumstances that occur during an in-home visit.

By voluntarily signing below, I confirm that I have read, or have had read to me, and understand the above Consent, have been told about and understand the risks of each of the TSW classes, activities, workshops and sessions, and have had an opportunity to ask questions and have received satisfactory explanations. I understand that I can request more information at any time if desired. I understand that I have the right to refuse or discontinue any service any time and that this refusal may affect the expected results I am seeking. I intend this consent form to cover current and future participation, and current and future wellness goals for which I seek these classes, activities, workshops and sessions.

**Third Space Wellness, LLC**

**PLEASE PRINT:**

\_\_\_\_\_  
Print Name \_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Email Address \_\_\_\_\_  
Preferred Phone Number

\_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_  
Emergency Contact Phone Number

\_\_\_\_\_  
**Signature** (or parent or guardian signature if client is a minor) \_\_\_\_\_  
Today's Date

- Please exclude me from your mailing list.  
We do not sell our mailing list.