Pilates Fusion LLC
Informed Consent

Name:_____cell#_____

Email Address:_____

A. I have been informed and acknowledge that in taking Pilates Fusion Instruction(virtually or in person) and/or having Physical Therapy evaluation and treatment by Sarah Wilson PT/CPI, I do so at my own risk.

B. I do hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation. I acknowledge that I have either had a physical exam and been given my physician's permission to participate, or that I have decided to participate in the activity without the approval of my physician and do hereby assume all responsibility for my participation and activities.

Do you have a history of:

_____Back Pain	_____Sciatica
_____Neck Pain	_____Hamstring or Quadriceps tightness
_____Osteoporosis/osteopenia	_____C-section or Abdominal Surgery
_____Pinched Nerve	_____Hernia/Type
_____Eating Disorder	_____Blood pressure issues
_____Cardiac Issues	_____Life threatening allergy

Any other condition that may preclude you from performing the exercises. Please explain:_____
_____

Client/Patient Signature:_____Date:_____

PT/Instructor Signature:_____Date:_____