Pure Serenity Massage LLC

"We Listen to Your Needs!"

Client Agreement Form

Please Initial Each Item Below

1._____ I am aware treatments may use extreme temperatures that can be modified. I understand that it is my responsibility to communicate any discomfort caused by the temperature or the pressure during the treatment.

2._____I agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Pure Serenity Massage, LLC

3._____I am aware that when I pay for my treatment ON THE SAME DAY OF SERVICE my price is at a discounted rate. If Pure Serenity Massage LLC is billing your insurance or billing client at a later date then the rate of $34.36-$37.56 per 15 minute unit is billed.

4._____If this account is assigned to an attorney for collections and or suit, the prevailing party shall be entitled to attorney's fees and cost of collections.

5._____I authorize release of my information to third parties (lawyer & collections) requiring these records for determination of financial liability, if I have not paid for the service rendered.

6._____ I understand that Massage Therapy is here for the purpose of stress reduction, relief of muscular tension, spasms, or for increasing circulation and energy flow.

7._____ I understand that Massage Therapists do not diagnose illness, disease, or any other physical conditions. I have stated all my known medical conditions and take it upon myself to keep the massage therapist informed of any changes.

8._____ I understand that Pure Serenity Massage LLC has the right to refuse service to anyone. I agree that if a therapist feels, for any reason, that they need to end your treatment early that they have the right to do so.

9._____I understand that our time together is precious. I agree to cancel 6 hours in advance for my appointment. If I am a no show without a call in to cancel I agree to pay ½ of the appointment fee. I agree that my credit card on file will be used to cover the late fee THE DAY OF the missed appointment.

10._____I understand that bounced/returned checks will result in a $30 fee plus the cost of the treatment.

11._____ I understand that if I am late to my appointment the therapists will end at the initial agreed *upon* time and a prorated price will not be accommodated.

By signing this application I affirm, I have given true complete information.

Date_____ Signature_____ Printed Name_____