CLIENT AGREEMENT

Please take a moment to read and initial all of the following statements:

__________ 1. If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/techniques can be adjusted to my level of comfort.

__________ 2. I affirm that I have notified my health care provider of all known conditions and illnesses. I also agree to inform my therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

__________ 3. I understand that my health care provider will create a treatment plan according to my needs and expectations.

__________ 4. I understand that should I cancel an appointment less than 24 hours before the scheduled time or " no show" an appointment, I am subject to a fee equal to the cost of the missed appointment. I understand that the receipt issued for this situation will not be submittable to my insurance company for reimbursement of funds.

__________ 5. I understand that if I am late for my appointment I will be charged in full for my originally scheduled treatment but the duration of my treatment will be reduced.

__________ 6. I understand that I am responsible for payment of treatment at the time of service.

____

CLIENT NAME

____

CLIENT SIGNATURE

____

DATE

____

HEALTH CARE PROVIDER SIGNATURE