CORRECTIVE
BODYWORKS
CLINICAL MASSAGE + SPORTS MEDICINE

I, ________________________________ (client/patient), understand that my health insurance policy may or may not cover services provided by a Massage Therapist or Athletic Trainer. As such, I understand and agree that I am personally financially responsible for paying any and all fees associated with and for such services.

I understand and agree to make payment in full for my massage therapy services, either in advance of or at the time the service is provided.

I understand Corrective BodyWorks accepts the following methods of payment: Cash, Credit Card (VISA and MasterCard), Debit Card, and Electronic Check.

I understand and agree that Corrective BodyWorks requires 24 hour-notice should it be necessary for me to cancel or reschedule an appointment. I understand a credit card is required to reserve an appointment at the time of scheduling. I further understand and agree that my failure to cancel an appointment at least 24 hours in advance or my failure to show up for an appointment (“no show”), will result in a charge of 100% of the scheduled appointment fee.

I understand that in the event of a missed payment, returned check (insufficient funds, etc.), or other reason causing me to have an outstanding account balance, Corrective BodyWorks will process these fees for payment.
I have read, understand, and agree with this financial agreement.

Date:_________________

Signature:____

Witness: ____

Date:__________________