



BALANCED THERAPEUTIC MASSAGE

A division of Balanced Chiropractic

780-997-0063

STATEMENT OF UNDERSTANDING & CONSENT FOR MASSAGE THERAPY TREATMENT

REGULAR FEE SCHEDULE (GST included)

1 ½ Hour: \$130.00 1 ¼ Hour: \$115.00 1 Hour: \$95.00 ¾ Hour: \$80.00 ½ Hour: \$65.00

SENIOR FEE SCHEDULE (GST included)

1 ½ Hour: \$125.00 1 ¼ Hour: \$110.00 1 Hour: \$90.00 ¾ Hour: \$75.00 ½ Hour: \$60.00

INSURANCE CLAIMS INFORMATION:

- Balanced Therapeutic Massage will direct bill most major insurance companies for your massage treatments, depending on your insurance company.
- Balanced Therapeutic Massage will consider a direct billing method if your treatments are a result of a Motor Vehicle Accident. Please speak with our Administration staff or, Therapist if this pertains to you.
- **In the event our MVA Auto Insurance Company does NOT pay for the full amount owing on each treatment, you will be responsible to pay the amount outstanding on your invoice.**
**** Failure to do so on any/all outstanding accounts will be forwarded to our select Collections Agent along with a monthly interest rate of 3%.**

CONSENT TO TREATMENT:

- I consent to receiving Massage therapy services from Balanced Therapeutic Massage and acknowledge that no guarantees have been made to me as to the results of the service rendered.
- I acknowledge that **NO** information will be shared by the staff at Balanced Chiropractic & Massage to anyone without written or verbal consent by the undersigned party to do so.
- Clients under the age of 18 must have parent/guardian **WRITTEN** consent prior to receiving Massage therapy treatment.
- I, the undersigned, certify that the information given in my health/case history is accurate, complete and current. I agree that it is my responsibility to keep my Massage Therapist informed of any changes in my state of health. I hereby release Balanced Chiropractic & Massage and their staff from any and all liability from problems arising from treatment as a result of information not given or, given incorrectly in this case history.
- I understand and I am willing to accept full responsibility for payment to Balanced Chiropractic & Massage, even if in the event that private coverage is denied.
- I acknowledge that my scheduled appointment time remains the same even in the event that I am late. The Therapist reserves the right to bill for the FULL treatment time.
- I acknowledge that my treatment time may also encompass general intake questions about your health or, previous treatment outcomes, homecare exercises and/or hydrotherapy treatment(s).

ADDITIONAL INFORMATION:

- ✓ Our staff requires at least **24 HOUR NOTICE** for cancellations as we may be able to fit another client in from a cancellation list. Our staff reserves the right to bill for the **full treatment time** or, a **\$20 no show fee** if in the event this has not been done.
- ✓ If you are more than **15 minutes late for your appointment**, your therapist will assume that you will not be attending and may fill your time with another client from our list.

PLEASE BE PREPARED TO MAKE FULL PAYMENT AT THE END OF EACH TREATMENT

Cash, cheque, master/visa card or debit is accepted

Signature (if under 18, parent/guardian must sign)

Date