1800 E Northwest Highway
Arlington Heights, Il. 60004
847-561-6593

Rates

50-Minute Theraputic Massages

Individual Session:	$ 80
Prepaid pack - 4 Sessions:	$300

Form of Payment: We accept cash, check, or credit card.

Third Party Insurance Coverage: Third party insurance (extended healthcare benefits) coverage varies from plan to plan. Please check with your insurance carrier for specific coverage. We will supply you with a receipt which you can submit for reimbursement should your carrier cover massages.

Tipping: Never expected, always appreciated.
(Small envelopes are on the front desk should you choose to leave your therapist a tip.)

New Massage Clients: Please plan to arrive at least 10 minutes PRIOR to your first massage session to complete a short intake form that your therapist will go over with you prior to beginning your massage."

Scheduling: A Credit Card on file is required to schedule your appointment or prepayment will be requested.

Late Arrivals: If you arrive late, your session may be shortened to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment given, you will be responsible for "full cost" of the cost of session. Out of respect and consideration for your therapist and other customers, please plan accordingly and be on time.

Cancellations: As a courtesy to our clients and staff it is our policy for all clients to give us a minimum of 24-hour notice for rescheduling or cancelling appointments. Failure to notify us within the given time will result in the loss of that session with no refund or credit.

Refunds: No refunds will be issued for any reason, including but not limited to relocation, illness, and unused sessions.

Gift Certificates: Gift Certificates expire 3 months from the date of purchase.

Consent and Waiver: This is a Therapeutic Massage session, and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that she deems necessary. Male and female genitalia and women's breasts will not be exposed or touched at any time. Draping will be used during a Massage Therapy session and only the area being worked on will be uncovered. Informed written consent must be provided by a parent or legal guardian for any client under the age of 17.

If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that the massage should not be

construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for mental or physical aliment that I am aware of.

1800 E Northwest Highway
Arlington Heights, Il. 60004
847-561-6593

I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose, and/or prescribe, and that nothing said during the session should be construed as such.

Because massage is contraindicated under certain conditions, I affirm that I will complete the massage intake form prior to my first massage and that I will state all my known medical conditions and answer all questions honestly. I agree to keep the therapist update as to any changes in my medical profile and understand that there shall be no liability on the therapists' part should I forget to do so.

I acknowledge that I have carefully read this release and waiver of liability and fully understand its contents. I voluntarily and knowingly agree to the terms and conditions stated herein. I am aware that by signing this release and waiver of liability, I am giving up substantial rights, including my right to sue and certain legal rights my heirs, next of kin, executors, administrators and assigns may have against any Released Party.

I have read and fully understand the above Release and Waiver of Liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Patient / Client Name Printed:____ **Date:**________________

Patient / Client Signature: ____

Legal Guardian Signature if Patient/Client under the age of 17yrs: ____

Relationship to Patient / Client: ______________________________