



Policies and Procedures

Welcome to Quietude Massage Therapy, Swearingen Inc.. The following is an explanation of our office policies and procedures. We believe that a clear understanding will allow us both to concentrate n the most important issue: regaining and maintaining your health. We are happy to answer any questions that you may have and grateful to be at your service.

The procedure time for treatment is 45-60 minutes. When you are scheduled, one full hour is set aside specifically to meet your needs. We do not double book appointments and are unable to place another client in your space without sufficient prior notice. Therefore, when you are scheduled it s imperative that you keep your appointment and that you arrive on time.

Our time is valuable. Therefore, **Cancellation Notice is required 24 hours MINIMUM prior to your appointment.** Twenty-four hours allows us to make your time slot available to another client in need of treatment. **If notice is not given, we will be forced to charge the full CASH DISCOUNTED price for the session. The fee must be paid prior to your next appointment.**

Our billed massage therapy fees for injury treatment massage are \$20.65-27.50 per unit (4 units=one hour). If the massage session is paid in full at the time of service, a "time of service discount" will apply. Under no other circumstances will this fee be adjusted. Understand and agree that the policies and procedures are an arrangement between carrier and client. Insurance will be certified and billed as a courtesy to you; however, the client understands that he or she is responsible for treatment not covered by the insurance. In the event that your insurance denies payment, you the client become responsible for payment in full. A 2% interest per month will be charged on balances over 60 days and can be turned over to United Collection Agency.

It is my choice to receive massage therapy. I realize and understand that massage therapists do not diagnose or prescribe. I agree to communicate with my practitioner regarding any changes in my insurance plan or circumstances. I further agree to communicate with my practitioner any time I feel my well-being is being compromised.

MY SIGNATURE INDICATES THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE POLICIES STATED ABOVE.

Client Signature _____ Date _____

Printed Name _____