**Pricing Terms and Conditions**

Touch of Balance, LLC

1717 Madison Ave. Suite 5

Loveland, CO 80537

(970)310-8644

(970)673-7378

**All prices are subject to change.**

**STRICT 24-HOUR CANCELLATION POLICY.** **Your appointments are very important to the staff here at Touch of Balance, LLC. It is reserved especially for you, we understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 24 hours notice for cancellations. Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and our staff misses the opportunity to make a steady income. Less than 24 hour notice will result in a charge equal to 50% of the reserved service amount. “NO SHOWS” will be charged 100% of the reserved service amount.**

**Credit/Debit Card hold.**

Due to the 24-hour cancellation notice, we require a credit or debit card to hold on your account. Providing your credit or debit card, you agree that Touch of Balance, LLC. has authorization to charge upon the circumstances listed above.

**Refunds through credit card.**

If you are unable to continue treatment due to medical purposes or a residential move, a refund will be issued. Due to the charged interest rate on the initial credit card transaction, a 5% charge will apply for the remaining refunded amount.

**Package deal terms apply.**

Package deals must be used within EIGHT (8) MONTHS from time of purchase and can be scheduled at your leisure.

**I have read and understand all pricing terms and conditions above.**

Printed name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_

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**Consent to Treatment Form**

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It is your responsibility to inform the therapist of any pre-existing conditions, limitations, or specific sensitivities and to inform your therapist if you feel any discomfort during the session. If you do experience discomfort, please ask the therapist to adjust the level of pressure.

Modest draping will be used during the session.

You understand and voluntarily accept any risks which you have been advised about associated with your massage, or from any use of Touch of Balance, LLC. facilities, and hereby release Touch of Balance, LLC. from all liability for any injury, including, without limitation, personal bodily or mental injury, economy loss or any damages to you resulting therefrom.

You further hereby release all of the foregoing personnel and entities from all liability arising from such injury or damage resulting from your failure to disclose any pre-existing condition, limitation, or specific sensitivities, or your failure to inform your therapist of any discomfort during the session. Your therapist may determine that it is unsafe for you to proceed with or continue a therapeutic session due to health related concerns.

By signing below, I do hereby voluntarily consent to be treated with massage, medical modalities and/or substances from the practice by therapists at Touch of Balance, LLC.

I understand that massage therapists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I understand that utilizing the services of Touch of Balance, LLC. and participation in massage therapy and related treatments is strictly voluntary and that I may discontinue services with Touch of Balance, LLC. at any time.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Printed name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_