InBalance Therapy Clinic

Kim Marsden
Remedial Massage Therapist
ABN: 58 104 247 878

1 Cramond Ave, Wangaratta, Vic. 3677
PO Box 1010, ph. 035722 1633
Provider No: AAMT 027 863

Service Agreement

Client Name: _____

1. I understand this clinic requires 24 hours to reschedule or cancel appointments to ensure those needing a appointment have the opportunity to have one, and that our day runs smoothly. I understand I may be liable for full payment for any appointments cancelled after this time.

2. I understand that the massage I receive is provided for the purpose of relaxation, lymphatic drainage and relief of muscular and soft tissue tension.

3. If I experience any pain/discomfort during my sessions, I will immediately inform the practitioner so the pressure/strokes can be adjusted to my level of comfort.

4. I understand that massage is not a substitute for medical examination, diagnosis or treatment and that I should see a physician or other qualified specialist for any medical conditions I'm aware of.

5. I understand that massage practitioners are not qualified to perform spinal or skeletal diagnosis or thrusting and that nothing said in the course of a session should be construed as such.

6. As massage should not be performed under certain circumstances, I affirm that I've listed all known medical conditions and answered all questions honestly.

7. I agree to keep InBalance Therapy Clinic updated as to any changes in my medical profile and understand that there shall be no liability on the clinic or practitioner's part should I fail to do so.

8. I authorize all employees and subcontractors of InBalance Therapy Clinic to discuss and correspond about my medical status as it pertains to providing me with safe and effective massage therapy.

By signing below, I acknowledge I have read and agree to abide by the conditions listed above.

Client Signature: Date: