DONALD K SHIFLET, DC
CHIROPRACTIC PHYSICIAN

MASSAGE THERAPY POLICY AGREEMENT & ACKNOWLEDGEMENT

Print Name ______________________________ Phone # (______)________________

Once you have booked a massage appointment with us it means that we have reserved our therapist's time exclusively for you. We understand that unanticipated events happen occasionally in everyone's life. We value your business and strongly believe that your time is as valuable as ours. In our desire to be effective and fair to all clients and staff, massage appointments are subject to the following cancellation policy:

Appointment Guarantee A credit or debit card is required to reserve massage appointments. Unless requested otherwise, you will not be charged now, payment will be collected in office at the time of your scheduled appointment.

Cancellation Fee Cancellation is free up to ***24 hours*** in advance. Appointments are in high demand and your advanced notice will allow another patient access to that appointment time. *After* 24 hours a **50%** late cancellation fee will be charged. *New and/or first appointments that result in a no show or late cancellation will be charged **100%** of the scheduled fee.*

Late Cancellations/No-Shows A cancellation is considered late when the appointment is cancelled less than ***24 hours*** before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, you will be charged a cancellation fee as outlined above.

How to Cancel Your Appointment If you need to cancel or reschedule your appointment time, please call us at (520) 877-2666. If necessary, you may leave a voicemail message. We will return your call as soon as possible. Cancellations by email *cannot* be accepted.

CREDIT CARD INFORMATION		
Cardholder Name (as shown on card):		
Credit Card Number:		Exp Date (mm/yy):
CCV/CVV Number:	Cardholder ZIP Code:	

YOU MAY CANCEL THIS AUTHORIZATION AT ANY TIME BY CONTACTING US. THIS AUTHORIZATION REMAINS IN EFFECT UNTIL CANCELLED.

I, ____, have read and agree to the above massage therapy policy. Furthermore, I understand and authorize **Back Benders Inc dba The Back Alley Chiropractic & Massage** to charge my credit card for agreed upon policy. I understand that my information will be saved to file for future transactions on my account.

______________________________ ______________
Patient Signature Date

2060 E Tangerine Rd #182, Oro Valley AZ 85755 **PHONE** (520) 877-2666 **FAX** (520) 877-9183