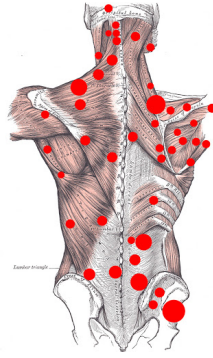


Clinical Massage Therapy

CMT Rocklin
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Office: 916.259.2510
Fax: 916.259.2511
Admin@clinicalmassagerocklin.com



CMT Folsom
2390 E. Bidwell #300
Folsom, CA 95630
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Chronic Maintenance Plan Membership Agreement

The following contains the terms of a Membership agreement between Clinical Massage California Inc DBA **Clinical Massage Therapy** and (Member Name) _____ on (Date)_____.

1. Memberships are billed monthly at the rate of **\$89.00**.
2. Membership dues are paid by monthly automatic electronic payments (credit card or debit card) starting on the date of sign-up and will continue until notice of cancellation is received.
3. This Membership may be cancelled by providing written notice, in person at any location or by email to **Membership@clinicalmassagerocklin.com**. The member agrees to submit cancellation by a minimum of 10 days prior to the next billing date in order to avoid the next scheduled payment. Without 10 days' notice **Clinical Massage Therapy** cannot guarantee payment will not occur as scheduled.
4. Upon Membership cancellation, a member has 60 days to redeem unused Treatments.
5. A member will receive **one 60-minute Treatment** per month with Membership and additional Treatments in the same billing cycle at \$89/ea.
6. While a Membership is active, unused Treatments may be rolled over for use by the member (not transferrable except as allowed per #7 below).
7. Member may transfer Treatments to a friend or family member twice per year.

8. Member may purchase Treatments for friends and family at the Membership rate twice per year.
9. Any credit on a member's account is redeemable for Treatment only and is not redeemable as cash.
10. A member will receive a 10% discount on all retail products.
11. Add-Ons may be provided at no additional charge. Add-Ons include:
 - a. Hot Stones
 - b. Heat Therapy
 - c. Cold Stones
 - d. Cold Therapy
 - e. Aromatherapy
 - f. Prossage®
 - g. Biofreeze®
 - h. Hand, foot, face, or scalp massage
12. Membership valid at all locations.
13. Members are required to notify **Clinical Massage Therapy** of changes in their billing information three days prior to the next scheduled billing date. Members may do so by phone or by emailing **Membership@clinicalmassagerocklin.com**
14. Members are required to notify **Clinical Massage Therapy** of any changes in address, email, or phone number. Members may do so by phone or by emailing **Membership@clinicalmassagerocklin.com**
15. All clients under 18 years of age must have written parental consent for Treatment to be provided. All clients under 16 years of age must be accompanied by a parent or guardian during Treatment.
16. Members are asked to arrive 10 minutes before your scheduled appointment time to prepare for a full Treatment.
17. **Clinical Massage Therapy** reserves the right to change clinic rules, regulations, and pricing at any time upon providing reasonable notice.
18. You may cancel your appointment without charge with a 24-hour notice preceding your scheduled Treatment.
19. Same day cancellations will incur a late cancellation fee \$40 charged to the card on file.

20. If you do not call to cancel or do not arrive for your scheduled appointment, you will forfeit a prepaid Treatment, if available, or be charged at the additional Treatment rate of \$79.
21. The Member may pause their Membership for periods up to three months with written notice delivered in person or via email to Membership@clinicalmassagerocklin.com. After the third month active Membership resumes and automatic payments begin to recur.
22. Memberships are non-transferable
23. Insurance billing services are not included with this Membership. Should a member obtain verification of coverage for medical massage, **Clinical Massage Therapy** will pause or cancel the Membership depending on a member's individual circumstances.
24. All members agree to follow clinic rules and regulations including Treatment terms & conditions and accept the Clinical Massage Therapy has the right to refuse or discontinue Membership to any member for any reason.

Name: _____ Date: _____

Signature: _____

Clinical Massage Therapy Representative Name: _____

Signature: _____