



CONFIDENTIAL CLIENT INFORMATION

Name _____ Date of Birth _____

Street _____ City _____ State _____ Zip _____

Daytime Phone _____ Email _____
(for 360 NMT purposes only)

INFORMED CONSENT

I recognize that neuromuscular and therapeutic massage services can legally be provided in Massachusetts without referral from a physician. By signing this document, I assume all risk for my health and well being, and hold harmless of any responsibility 360 NeuroMuscular Therapy LLC or any persons involved with this program. I hold harmless and agree to indemnify 360 NeuroMuscular Therapy LLC, and its agents, servants and employees from any and all claims, damages, losses, expenses, costs and liabilities arising out of the delivery and receipt of services from 360 NeuroMuscular Therapy LLC other than that which is due to the gross negligence or willful misconduct of its agents, servants and/or employees. I have discussed my own physical limitations and/or suspected health concerns with 360 NeuroMuscular Therapy.

I acknowledge that I am solely responsible for my bill and that payment is dues in full at the time of treatment. I agree to give 24 hours notice of cancellation of appointment. If less than 24 hours notice is given, I agree that 360 NeuroMuscular Therapy may charge for the time if unable to fill the appointment. Cases of extreme emergency are considered exceptions.

Signature _____ Today's Date _____

Parent/Guardian signature if client is under age 18 _____