(732) 528-7746

1903 Atlantic Avenue B-2, Manasquan NJ 08736

www.DrStiso.com

MASSAGE PAYMENT OPTIONS: (Select One)

	60 MINUTE	90 MINUTE	Reflexology
□ PAY AS YOU GO	\$69.99	\$99.99	\$69.99 <i>45 Minutes</i>
☐ PREPAID PACKAGES			
□ PREPAID 3-PACK	\$195 (save \$15)	\$285 (save \$15)	\$195 (save \$15)
□ PREPAID 5-PACK	\$320 (save \$30)	\$470 (save \$30)	\$320 (save \$30)
☐ ANNUAL MEMBERSHIP	P (Automatic Payments	Charged Monthly)	
\Box 1 per month: (save \$60/y	year) \$65	\$95	\$65
□ 2 per month: (save \$180 <i>i</i>	/year) \$125	\$185	\$125
☐ 3 per month: (save \$360/	/year) \$180	\$270	\$180
☐ 4 per month: (save \$600 <i>i</i>	/year) \$230	\$350	\$230
□ Over 4/month: +	-Add \$50 each addition	al \$70 each additional	\$50 each additional
Massage packages are NOT based accommodate special requests, howe are unwilling to be seen by a therapi purchase date. Annual memberships future monthly payments. Massage patime ONLY package option change Unused massages will carry NOT of services rendered are non-refundable the "pay as you go" fee schedule and the same way it was made. Late/Cancellation Policy – If you are	ever, such requests are NO' ast other than the one you reare billed to the below cred ackages can not be shared by which allows you upgrade over to the following months. If you choose to discontinually a \$15 administrative fee where the to your appointments.	ny particular massage then Γ guaranteed. Refunds/raincequested. Prepaid packages lit card beginning of each moetween multiple clients. All the or downgrade the original th(s). As with all healthcare so that a pre-paid plan early, the vill be applied. The remaining ent the minutes will be deduced.	hecks will not be granted if you expire 1 year from membership onth, and will be kept on file for annual members are allowed a 1 annual package option chosen. pecialties, payments for massage he used visits will be prorated to high balance will then be refunded exted from your massage and will
NOT carry over to your next appoint ONLY) or a \$25 charge will be appli the entire pre-paid visit. I have read and understand the	ed for time reserved. Failur office policies above an	te to show for and appointment ad agree to the payment	ent with result in the forfeiture of option selected above. I give
Frank R. Stiso, DC, LLC permi	.		
Patient Name: (PRINT)			
Signature:		Date:	
Parent/Legal Guardian (if under 18))•		