Absolute Therapy, LLC

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ABSOLUTE THERAPY SPA MEMBERSHIP AGREEMENT		
PERSONAL INFORMATION		
Name:		
Email:		
Date of birth:	Phone1:	Phone2:
Current address:		
City:	State:	ZIP Code:
EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		Phone:
City:	State:	ZIP Code:
ADDITIONAL CONTACT		
Name:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		
MEMBERSHIP PAYMENT INFORMATION		
Monthly Fee: $80.00		
Date to be drafted: 1st 16th	Card Type:	
Card #:		
Expiration:	CVC Code:	Zip Code:
I authorize Absolute Therapy, LLC, to draft the amount of my monthly spa membership from the credit card listed above. I understand that my account will be drafted on the due date indicated of each month until otherwise specified. I understand that I have the right to stop payment at any time after the first initial payment. Sign: Date:		
UNDERSTANDING OF RULES AND REGULATIONS		
I certify that I have read and understand the rules and regulations that were provided to me and I will comply with the consensus herein. Sign: Date:		