Massage Therapy Consent and Authorization:

- All new massage clients will have a consultation with the Massage Therapist and an assessment prior to receiving their first massage.
- Upon completion of the consultation, and assessment of the problem area(s) will be done in order to determine what kind of treatment plan is required and if massage will benefit you in your quest for better health. An assessment is required to rule out any injury or disease that may make massage treatment unsafe or inappropriate.
- Please provide a minimum of 24 hours notice for any cancellations. Failure to do so may result in a missed appointment fee. If the massage therapy is being paid for by third party billing, YOU are responsible for the missed appointment fees.

Informed Consent to Massage Therapy Treatment

I hereby consent to my Massage Therapist to treat me with massage therapy for the above noted purposes including such assessments, examination and techniques, which may be recommended by my Therapist. I am aware of the purposes of massage therapy and should any concerns arise at any time I will not hesitate to discuss them with my massage therapist.

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment I may be experiencing. I acknowledge that with any treatment there can be risks and those risks have been explained for me and I assume those risks.

I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history for as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. I have given my therapist valid information regarding my health condition to the best of my knowledge, and will not hold them responsible for further complications herein. It is my responsibility to keep the Massage Therapist updated in my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Massage Therapist to release or obtain information pertaining to my condtion(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the consents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Massage Therapist from time to time to deal with my physical conditions for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Dated this _____ day of _____, 20___.

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ Name:_____

(please print) **(please print)**