INFORMED CONSENT

I understand that the massage therapist is providing massage therapy services within their scope of practice.
I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by the therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness, disease, and other physical or mental disorders. I clearly understand that massage therapy is not a substitute medical examination. It is recommended that I attend my personal physician for any ailments I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me the results of the treatment. I acknowledge that with any treatment, there can be risks and risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing conditions. I have completed my medical history form as provided by my therapist and disclosed the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) treatment to/from my other caregivers or third party payers, only when necessary and only with prior verbal/written request.

By signing this form, I confirm my consent to treatment and intend this consent to cover treatment discussed with me and such additional treatment as proposed by my therapist, to deal with my physical condition and for which I have sought treatment. I understand any time, I may withdraw my consent and treatment will be stopped.

CANCELLATION POLICY:

I understand that if I must cancel an appointment, I will provide 24-48 hours notice prior to the scheduled appointment time. If I fail to do so, I agree to pay for the service at the discretion of the therapist (illness, family emergencies are exempt with notice).
** Simply not arriving for my treatment will result in an invoice for the full amount. **

Patient Signature _____

Guardian Signature (If under 18) _____

Date Signed _____
(mm/dd/yyyy)