Massage Informed Consent

I hereby request and consent to the performance of massage therapy and other massage therapy procedures, including various modes of physical therapy and modalities on me (or on the patient named below, for whom I am legally responsible) by the licensed massage therapist named below.

I understand that results are not guaranteed and that massage therapy is not intended as a substitute for a medical examination and is not designed to diagnose a medical condition, offer medical treatment or prescribe medications. I understand that a massage should not be done when certain medical conditions exist, and I have informed the therapist of my current medical condition. I am informed that, as in the practice of medicine, in the practice of massage therapy there are some risks to treatment. I do not expect the therapist to be able to anticipate and explain all the risks and complications, and I wish to rely on the therapist to exercise judgment during the course of the massage which the therapist feels at the time, based on the facts then known to the therapist, is in my best interest. I acknowledge that I need to tell the therapist if the pressure or stokes are too hard or cause pain.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand that if I cannot keep my appointment that I will call to reschedule as soon as possible. I also agree and understand that if I no-show to an appointment that I will be charged a $25.00 no-show fee, at therapist's discretion, which is not reimbursable through my insurance and will be paid prior to any upcoming appointment. Should my account go to collections, I understand that I may be charged a 35% collection fee on my outstanding balance.

Patient Signature: _____ Date: _____

Patient/Guardian Signature: _____Date:_____

LMT Signature: _____ Date: _____