

Informed Consent for Massage Therapy

I understand that my massage therapist is providing a massage therapy service within her scope of practice by providing relaxation, pain reduction, improving circulation and range of motion, hydrotherapy, remedial exercise and assessments.

I am aware of massage therapy contraindications and understand the treatment procedure that has been explained to me. I am aware that my massage therapist does not diagnose an illness or disease, prescribe medication or perform spinal cord manipulations. It is recommended that if I do have a condition that I should contact my primary health care provider. I understand that results may not be guaranteed and have discussed the risks and results of my treatment with my therapist.

I understand I have the right to terminate my treatment at anytime. I also understand that I have the right to alter my treatment and/or rescind my consent at anytime. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions and understand that it is my responsibility to inform my therapist if there are any changes. I have truthfully completed my health history form as provided by my therapist to the best of my knowledge.

I authorize my consent to allow my therapist to release or obtain information pertaining to my conditions and/or treatment to/from any other health care practitioner or third party.

I understand and acknowledge that the information obtained by my therapist will be kept for a minimum of 7 years in accordance with massage therapy regulations and that during that time I have the right to obtain a copy of this information.

I have read the consent above and have had the opportunity to ask questions about the consent and treatment. By signing below I hereby agree to the above.

I agree to pay my full account at the time of each visit or treatment, including fees for services as well as other applicable fees.

Parents/Guardians

I agree that I am solely responsible for the safety of my child/children while on the premise of TouchStone Health. Children are to be supervised at all times and never left unattended by the parent.

Cancellation Policy

I agree that if I am unable to make my appointment, I must provide advance notification within 2 business days. Failure to provide notice will result in a charge equivalent to the cost of the appointment that was missed.

Patient Name: (Please print name): _____

Signature of Patient or Guardian: _____

Date: _____ Registered Massage Therapist: _____