Synergy Bodyworks

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Massage Therapy Consent Form

I, _____, (client) understand that massage therapy provided by, Chelsea Thompson is intended purpose is to enhance relaxation, reduction of stress, relief from pain caused by muscle tension or spasm, increase range of motion, improve circulation and offer a positive experience of touch. I accept that a single massage session is limited to providing general non-specific benefits. Other than to determine contraindications, I understand that there will be no extensive assessment performed. If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

I understand that massage therapy is not a substitute for a medical examination, diagnosis, treatment, or medications, and it is recommended that I seek my primary healthcare provider (PHP) for any of those services. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. Due to certain contraindications and cautions for massage, the therapist must be aware of existing physical and mental conditions. I have informed the massage therapist of all my known physical, medical, and mental conditions and medications. It is my responsibility to update the massage practitioner with any changes in my health status. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

I have received a copy of the policies. The general benefits of massage therapy, possible cautions or contraindications and the treatment procedure have been given to me. I have read them, and I understand and accept them. The qualifications of the massage therapist have been disclosed to me.

Chelsea Thompson and all employees of Synergy Bodyworks are not responsible for the loss of your valuables or personal property. (Please check the room for your valuables, such as jewelry and glasses). I have reviewed the therapist's policies, and I understand them and agree to abide by them. I acknowledge that with any treatment there can be risks and I assume those risks.

Signature: _____ Date: _____

Witnessed By:_____Date: _____

801 S. Adams Rd. Suite 209 ● Birmingham, MI 48009● (248) 330-7754 Tel ● SynergyEst2008@gmail.com