

## **MASSAGE THERAPY INFORMED CONSENT**

14355 SW Allen Blvd. STE 150, BEAVERTON, OR 97005 (503)806-5700

I understand that massage therapy that I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any explicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

LMT Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Consent to Treatment of a Minor: By signature below, I hereby authorize the Licensed Massage Therapist(s) to administer massage therapy to my child or dependent as they deem necessary.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_