CONSENT FOR TREATMENT

I hereby state that the information that I have filled in is true and accurate to the best of my knowledge. I agree to communicate with my Medical Doctor or Maternity Healthcare Provider as deemed necessary that I am receiving prenatal massage. I understand that my personal and medical information (both written and spoken) is confidential and will only be disclosed to third parties with my permission. I also understand that I am expected to notify my CMT if there are any changes to my health/pregnancy OR if I am uncomfortable with ANY part of my massage therapy treatments. I verify that I am aware of the possible benefits and the contraindicated conditions for massage therapy during the term of pregnancy. I am aware that I need to consult with my Maternity Doctor/Healthcare Provider PRIOR to receiving massage therapy if I am a High Risk Pregnancy or am experiencing any contraindicated conditions in which it would be inadvisable for me to receive massage.

I understand that I will be receiving massage therapy as an adjunctive form of healthcare only, and that I must continue to receive appropriate medical care from my Medical Doctor/Maternity Healthcare Provider.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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