Kathy Conyers, LMT #59266

 Massage Therapist

**Informed Consent to Massage Therapist Treatment**

I hereby consent to examination by my Massage Therapist, which may involve removal of some clothing articles, palpation (manual examination) of body part(s) and close observation of body part(s). I consent to the use of photographs for postural comparison and educational purposes during evaluation and reevaluation.

I hereby consent to treatment by my Massage Therapist, within her scope of practice. I understand that the treatment will be discussed with me prior to its application and that at any time I have the right to refuse treatment. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and that those risks have been explained to me and I assume those risks.

I acknowledge that my Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form and have disclosed to my Massage Therapist all of the medical conditions affecting me. It is my responsibility to update my therapist on my medical history.

I have read the above noted consent. By signing this form, I consent to evaluation and treatment by my Massage Therapist. I understand that at any time I may withdraw my consent and treatment will be stopped.

\_\_\_\_\_\_I understand that I am responsible for payment in full at the end of each session.

\_\_\_\_\_I have been advised of potential risks and side effects of myofascial release treatment and I freely and voluntarily consent to treatment.

\_\_\_\_\_I hereby agree to hold Kathy Conyers, LMT harmless for any claims and liabilities associated with treatment.

\_\_\_\_\_I am aware of the late policy as well as no show policy of this establishment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature/Date