Informed Consent

I ________________________________ have received, read and understand the policies and procedures of Applied Therapies LLC. The Therapist has informed me of her qualifications, the kind of massage services to be provided, the benefits, risks and the goals of the session(s) that we have agreed upon. I understand that I retain the right to withdraw my consent at any time during any session.

I ________________________________ understand that the massage services provided by Applied Therapies LLC are intended to promote relaxation and circulation, and relieve stress, muscle tension, spasms and related pain. I understand that Massage Therapy is not a substitute for medications or medical treatment and that the Massage Therapist does not diagnose illness nor prescribe medical treatment or perform spinal manipulations.

I have informed the therapist of my medical and physical condition(s) and of medications I use, and I agree to update the Therapist of any changes in my health profile. I release the Therapist of any liability if I fail to do so.

If I experience any discomfort or pain during any session, I will immediately inform the Therapist so adjustments can be made to the treatment.

Client Signature__________________________________
Date__________

Consent to treat a minor

I, the parent or legal guardian of

____
Authorize Applied Therapies LLC to provide therapy to my dependent or child.

Parent or Guardian Signature_________________________ Date____________

Therapist Signature________________________________ Date____________

Revised 5/18