nw orthomassage

7500 212th st SW, Suite 101
Edmonds, WA 98026
T: 425.776.6966
F: 425.776.6969
info@nworthomassage.com

Massage Therapy Informed Consent

I, _____, (Patient or Guardian) understand that massage therapy provided at NW Orthomassage is intended to promote healing, reduce pain, enhance relaxation, increase range of motion, improve circulation and overall offer a positive experience. Any other intended purposes of massage may be listed below. I acknowledge my understanding.

The general benefits of massage, possible contraindications and the treatment procedures have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any conditions I may have. I am aware that massage therapists do not diagnose illnesses or diseases, do not prescribe medications, and that spinal manipulations are out of the scope of practice. I acknowledge that with any treatment there can be risks and those risks are assumed to me.

I have informed my therapist of all my known physical conditions, medications and medical conditions. I will also continue to keep the massage therapist updated on any changes that may occur. I understand that there shall be no liability on the practitioner's (Licensed Massage Therapist) part due to my failure to relay pertinent information. The information I have provided is true and complete to the best of my knowledge.

I understand that if I experience any pain or discomfort during the session, it is my responsibility to immediately communicate that to the therapist so the treatment may be adjusted.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregiver or third-party payers.

Some techniques provided by our therapists may cause discoloration (blanching) of the skin, bruising, and/or some tenderness. Generally 24-48 hours post treatment you may feel delayed onset muscle soreness. Please inform us of any pain lasting longer then 3 days.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing below, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient (Guardian) Name:_____

Patient Signature (Guardian): _____Date:_____