SERENITY PHOENIX
WELLNESS
Massage Therapy & Functional Body Work

Informed Consent to Treat & Patient Release:

I understand that the Certified Massage Therapist (CMT) is providing massage therapy services within their scope of practice as defined by the California Massage Therapy Council (CAMTC). I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist. **I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder.** I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. 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 those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge. I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers as required for my continued therapeutic treatments.

I have read the above noted consent and I have had the opportunity to question the contents and the therapeutic plan or appointment plan recommended by my Certified Massage Therpaist. By signing this form, 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.**

Hot Stone Massage Contraindications & Release / Decline:

Hot stone massage is not suitable for everyone. There are risks associated with performing hot stone massage on individuals with the following conditions. You must inform your massage therapist/practitioner if you have any of the following conditions which may make hot stone massage contraindicated or may require your therapist/practitioner to alter the massage.

- ☐ *Pregnancy*
- ☐ *Inflammatory skin conditions*
- ☐ *Peripheral vascular disease*
- ☐ *Compromised immune system*
- ☐ *Edema or Lymphedema*
- ☐ *Under the influence of drugs/alcohol*
- ☐ *Blood clot(s)*
- ☐ *Autoimmune conditions*
- ☐ *Hypo/Hypertension*
- ☐ *Varicose veins*
- ☐ *Cancer*
- ☐ *Diabetes*
- ☐ *Open wounds/sores*
- ☐ *Heat sensitivity*
- ☐ *Cardiovascular disease*
- ☐ *Neuropathy*

I, _____, have read and understand the aforementioned conditions which make hot stone massage contraindicated. The massage therapist/practitioner has discussed this information with me and provided opportunity for any questions. I have disclosed any and all health risk factors.

√ ***Please check the following that applies to you:***

- ☐ **I understand the information contained on this form and confirm that I do not have any of the above conditions.**
- ☐ My condition(s) of _____ is/are listed above and therefore make(s) hot stone massage contraindicated. Given this knowledge I hereby give my full consent to receive hot stone massage and take full responsibility of any side effects or harm that may come from my receiving hot stone massage.
- ☐ I understand that I will be receiving hot stone massage as an adjunct form of healthcare only and that this therapy is not meant to replace appropriate medical care. I release the massage therapist/practitioner of any and all liability for any harm that may unintentionally occur during my treatment(s) with the knowlegde my therapist is using best practices and all possible precautions.
- ☐ **I understand the information contained on this form and DECLINE hot stone inclusion as part of my treatments.**

_____	_____	_____ _____, 20___
Client Name (Please Print)	*Client Signature*	*Date*

JASON VILLALOBOS C.M.T., 5444 YOLANDA AVE., SUITE 210, TARZANA, CA 91356
DIRECT: (310) 598 1533 JASON@SERENITYPHOENIX.COM WWW.SERENITYPHOENIX.COM