**Consent for Treatment**

To proceed with receiving care, I confirm and understand the following (Initial in all places provided)

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.
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I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.____________

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care.____________

I have been offered a copy of this consent form.____________

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FORWHICH I SEEK CARE FROM THIS OFFICE.

**- continued on back -**

- Techniques to be used may include Swedish, Deep Tissue, Trigger Point, Reflexology, Visceral Manipulation, ROM and stretching, or Kinesio Taping.
- Body parts to be massaged include face, neck, shoulders, back arms, buttocks, hip flexors, legs (front and back), pectorals, abdominals, ribs and feet.
- The massage therapist will NOT engage in breast massage. Genitals are ALWAYS excluded.
- Standard draping practices will be used, meaning only the body being massaged will be exposed.

I understand that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform spinal adjustments. Massage therapy is not substitute for medical examinations and diagnosis. It is recommended that I see a physician for any physical ailment that I might have. I understand that the message therapist does not diagnose illness, disease, or any other physical or mental disorders. Any sexual misconduct exhibited by the client will result in immediate termination of the session, and the client will be liable for payment of the scheduled appointment. **If I cancel, reschedule or skip an appointment without 24 hour notice or more, I agree to pay the full session fee**. If for any reason the client is uncomfortable, the client may ask the therapist to cease the massage and the therapist will end the session.

I have reported all health conditions that I am aware of and will inform my therapist of any changes in my health. All information provided is correct and current to the best of my knowledge.

Client Printed Name ______________________________________ Date: _______________

Client Signature _______________________________________________________________

Therapist Signature: _____________________________ Date: __________________

**Consent to treatment of minor**:

By my signature, I authorize Rockwall Medical Massage to administer massage or bodywork techniques to my child or dependent as they deem necessary.

Parent or Guardian Signature _______________________________ Date: ________________