

## MASSAGE THERAPY CONSENT

I understand that the massage given to me at ThriveAgain Physical Therapy & Wellness is for the purpose of stress reduction, pain reduction, relief from muscle tension, and increasing circulation.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver and physical therapist for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that the massage may times elicit discomfort, and agree to immediately tell my massage therapist if I am in discomfort or if I would like any aspect of the massage to be changed or stopped.

If I have questions about or trouble with any part of my massage, I will discuss it promptly with my therapist.

### INFORMED CONSENT FOR TREATMENT

#### POTENTIAL RISKS

I may experience an increase in my current level of pain or discomfort, an aggravation of my existing injury or condition, an aggravation of a previously existing condition, or an onset of new symptoms. Any discomfort is usually temporary and if it does not subside in 48 hours, I agree to contact my massage therapist.

#### POTENTIAL BENEFITS

I may experience an improvement in my symptoms and an increase in my ability to perform daily activities and athletics. I may experience increased relaxation and improved tissue healing. I may experience decreased pain and discomfort. I may gain a greater knowledge about managing my condition and the resources available to me.

#### ALTERNATIVES

If I do not wish to participate in massage therapy, I will discuss my medical, surgical or pharmacological alternatives with my therapist and my physician or primary care provider.

**NO WARRANTY**

I understand that there are no guarantees have been or can be provided regarding a cure for or improvement in my condition. I understand that if I am uncomfortable with the assessment or treatment procedures at any time, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

**CONSENT FOR COMMUNICATION WITH OTHER THRIVEAGAIN STAFF**

If I am receiving physical therapy at ThriveAgain, I consent for my massage therapist to give information to and receive information from my physical therapist to maximize my benefit from massage therapy.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I have informed my therapist of any condition that would limit my ability to receive massage. I hereby request and consent to therapeutic massage to be provided by the massage therapists of ThriveAgain. Physical Therapy & Wellness.

Patient Name (Printed) \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_