



numinosity

Informed consent for routine clinic services (excludes psychotherapy)

Patient Name: _____

Please initial and date the following consents for services received.

_____ **CONSENT TO ROUTINE MASSAGE SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Gina C. James and/or other licensed massage therapists who now or in the future treat me while employed by, working or associated with or serving as back-up for the massage therapist named above. I understand and am informed that, in the practice of massage therapy there are some risks to treatment, including but not limited to sore muscles and joints, increased risk of emboli from varicose veins, and increased blood pressure from hypertension. I do not expect the massage therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the massage therapist to exercise judgment during the course of the procedure which the massage therapist feels at the time, based upon the facts then known, and is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

I, OR MY REPRESENTATIVE, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.

Signature of Patient

Date

Signature of Insured/Agent

Date

If patient is under the age of 18, or is otherwise unable to sign, please complete the following:

Patient is _____ years of age OR unable to sign because: _____

Signature of Patient

Date

Relationship to patient