Essential Therapies Informed Consent Form

Please read carefully and sign before receiving service. All information provided is confidential and will not be given out to anyone.

I understand that Myofascial Release Sessions (including use of massage, soft tissue mobilization and/or Myofascial Release) given to me by Cindy Hodgson and associates is for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, increasing range of motion and/or to enhance the body's own healing capability.

I understand that this is a wellness service, and that I will not be diagnosed for injury, illness or disease as well as not prescribed medical treatment or pharmaceuticals. I understand that this wellness service is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I understand that Myofascial Release Sessions require the practitioner to observe and touch my body in order to conduct this service. I am aware that this work is performed directly on the skin and acknowledge that I need to tell my practitioner if the pressure or strokes are too hard or cause pain.

I understand that draping techniques are dictated by my treatment response and are therefore recommended to wear a undergarments, bathing suit (or similar dress) to allow my practitioner appropriate skin access, as well as allow my body to move freely without restriction while maintaining modesty.

I understand that techniques and/or sessions can be stopped at any time. I understand that any illicit or sexually suggestive remarks or advances made will result in immediate termination of the session.

I also understand the practitioner has the right to refuse or terminate the session to anyone whom he/she is considered to have a condition for which Myofascial Release (including massage and soft tissue mobilization) is contraindicated.

In completing my Medical Intake form, I have informed my practitioner of all my known physical and medical conditions and medications, and attest that the information I have provided is true to the best of my knowledge and that I have not withheld any information regarding my health.

If I continue my wellness services I agree to keep my practitioner updated of any changes to my medical profile if they occur, and understand there will be no liability on the practitioner's part if I fail to do so.

Client Signature: _____ Date: _____