

**Massage Therapy Consent**

NAME

REG. NO.

BIRTHDATE

Please identify yourself (check one):

 **Hospitalized Patient (Inpatient)** **Client registered in UMHS (Non-hospitalized)** **Other:** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

- I agree to have massage therapy. I understand a certified massage therapist will work on areas of tension, pain, or limited motion. He or she may use different techniques, like stroking, kneading, friction, and/or percussion.
- The most common **risks** of massage include:
  - Mild, short-term muscle soreness
  - Surface level bruising
  - Aggravation of an undiscovered broken bone

I understand that it is **extremely important to tell the massage therapist about any known physical and/or medical conditions and medications I am taking**, and to let the therapist know about any recent changes. I understand there may be additional risks applicable to me based on my physical and/or medical history and condition.
- I understand the massage therapist will check with me from time to time during my massage to make sure he/she is using the appropriate technique and pressure for me, as was agreed upon at the beginning of the appointment. I recognize it is important to give honest feedback to the massage therapist. Changes can and will be made to fit my needs. If I do not like what the massage therapist is doing or how it feels at any point during my treatment, I agree to tell him/her immediately. I know the therapy can be stopped at any time.
- It is hoped that the massage therapy will help increase circulation, improve mobility, reduce pain, and/or induce deep relaxation caused by muscle tension. I understand that massage therapy is not an exact science. I have been told about the probability of success. However, **no promises or guarantees** have been made, or can be made to me about the success, outcomes, or side effects of the therapy.
- I understand that massage therapy is **not a substitute for medical treatment or medications**, and that the massage therapist does not diagnose illness or disease, and does not prescribe medications.
- I understand my physician is made aware of my request for massage therapy, if I am an inpatient.
- The information collected during massage therapy sessions may become part of my regular medical record and discussed with my health care team.
- I understand that unexpected events may happen before or during massage therapy. This may require changing the provider originally scheduled to perform the therapy.
- I have been given a chance to ask questions about the planned massage therapy and my questions have been answered. I have read and understand the information on this form before I signed it.
- I request and authorize the University of Michigan and any certified massage therapists who may be assigned to my case to administer massage therapy. More information about certified massage therapists is available from the National Certification Board for Therapeutic Massage & Bodywork, online at <http://www.ncbtmb.com/>.

Patient/Client may request a copy of this document for her/his health records.

 No, I do not want a copy. Yes, Please mail a copy to: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_  
Signature of Patient/Client or Legally Authorized Representative (If patient/Client is a minor or unable to sign)\_\_\_\_\_  
Date (mm/dd/yy)\_\_\_\_\_  
Printed Name of Legally Authorized Representative (If patient/Client is a minor or unable to sign)Relationship:  Spouse  Parent  Next-of-Kin  Legal Guardian  DPOA\_\_\_\_\_  
Consent Obtained, Explained and Witnessed by (Name):\_\_\_\_\_  
Signature\_\_\_\_\_  
Date(mm/dd/yy)\_\_\_\_\_  
Time\_\_\_\_\_  
A.M./ P.M.

Page 1 of 1