Riverside Chiropractic Center of Seneca, Ltd.

Informed Consent
for Massage Therapy

I understand that Massage Therapy is for the purpose of stress reduction, relief from muscular tension, general relaxation and improvement of circulation. I understand that the Massage Therapist does not diagnose illness, dis-ease or any other physical or mental condition and that no conversations or statements made during or relating to our sessions should be construed as such. The Massage Therapist neither prescribes medical or pharmaceutical treatment nor performs any spinal adjustments. It has been made clear to me that professional Massage Therapy is not a substitute for medical or chiropractic treatment. I understand that it is recommended that I see a physician to verify that there is no medical reason that I should not undergo Massage Therapy and for any physical ailment that I might have. I acknowledge that any sexual or implied sexual comments or actions on my part will result in immediate termination of the massage session and I will be responsible for any and all charges in full. I understand that I may be held responsible in full for any missed appointments without prior notice or for any cancellations made less than 24 hours in advance.

I have read and understand the above statement. I have stated all of my known medical conditions on the Patient History Form. I take it upon myself to keep the Massage Therapist updated on my current health.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE RIVERSIDE CHIROPRACTIC CENTER TO PROCEED WITH MASSAGE THERAPY CARE AND TREATMENT.

CONSENT TO TREAT MINOR

I hereby authorize Riverside Chiropractic Center of Seneca, Limited and whomever they may designate as Massage Therapist and assistants to administer therapy as they do deem necessary to my Son / Daughter, _____
(circle one) (child's full legal name)

I authorize Riverside Chiropractic Center of Seneca, Limited and said Therapists and Assistants to treat the above listed child in the absence of my presence under normal office visit circumstances. _____Date:_____
(parent/guardian signature)

Having the above knowledge, I knowingly authorize Riverside Chiropractic Center to proceed with Massage Therapy care and treatment.

Self or Parent/Guardian Signature:_____Date:_____
(if patient is a Minor)

Massage Therapist Signature:_____Date:_____