



PACIFIC COLLEGE of HEALTH AND SCIENCE

Informed Consent to Massage Treatment

I understand that the massage I will be receiving at Pacific College of Health and Science (PCHS) is for the purpose of general wellness, stress reduction, balancing of energy (qi), the promotion of circulation and flexibility, and relief from muscular tension. I understand that the massage therapist does not diagnose illness, disease, or any further physical or mental disorders. As such, the massage therapist does not prescribe medical or pharmaceuticals, nor do they perform spinal or skeletal manipulations. I understand that massage is not a substitute for medical treatment or diagnosis and that it is recommended that I see a physician for any physical or mental ailments that I may have.

I have been informed that Massage; Tui Na, Swedish, Shiatsu, Reflexology, and Thai, is a safe method of treatment, but that it may have side effects, including bruising, numbness, muscle soreness, nerve symptoms, dizziness or fainting.

Massage/bodywork should not be performed under certain medical conditions, and I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the student-practitioner (and PCHS) updated as to any changes in my medical profile (such as pregnancy, surgery, injury, or illness) and understand that there shall be no liability on the part of PCHS and its students, should I fail to do so. I understand that if I experience any unusual discomfort and/or pain during my massage sessions, it is my responsibility to inform the massage therapist so that they can adjust the pressure or technique being used.

I understand that PCHS clinical and administrative staff may review my medical records, and that portions of my records may be used for teaching or research purposes; however, my name and identifying information will not be disclosed. Otherwise, all of my records will be kept confidential and will not be released to any party without my written consent, in full compliance with HIPAA regulations.

I agree to abide by a professional code of conduct at all times. I understand that the session may be terminated if I refuse to do so. Any unprofessional conduct made by the student should be reported to PCHS clinic management immediately

Client Printed Name: _____

Date: _____

Client Signature: _____

Date: _____

Intern Signature: _____

Date: _____

Supervisor Signature: _____

Date: _____