



NY State License No: 016224-1  
National License No: 394023-00

**Marianne Brunner**  
**(518) 381-4046**

## **Informed Consent to Medical Deep Tissue Massage Therapy**

**Patient: Please discuss any questions or concerns with your therapist before signing this consent.**

I hereby request and consent to the performance of medical deep tissue massage therapy on me by the named therapist above.

I have had the opportunity to discuss with the therapist the purpose and benefits of medical deep tissue massage therapy and the various techniques outlined below.

Though medical deep tissue massage therapy is usually beneficial and seldom cause any problems, I understand and am informed that there are times when the work may cause an acute flare up or various physical reactions as the body begins the healing process. These reactions include, but are not limited to, an aggravation of present conditions, inflammation, pain, headaches and bruising.

I understand that medical deep tissue massage therapy is not meant to be painful and at times some of the work can feel tender as it is applied. I understand that I have full control of the amount of depth the therapist will use and accept the responsibility to fully communicate my desired pressure to the therapist at all times.

I understand that medical deep tissue is not an exact science and that, therefore, results cannot be guaranteed. I acknowledge that no guarantee or assurance has been made by the therapist regarding the proposed treatment that I have requested and authorized. I have had the opportunity to ask the therapist questions regarding the proposed therapy. My questions have been answered to my satisfaction.

### **I ACKNOWLEDGE THT I HAVE READ AND UNDERSTAND THIS STATEMENT.**

Name of Patient: \_\_\_\_\_ (PLEASE PRINT)

Signature of Patient \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_  
(if patient is a minor)

Therapist Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_