Oregon Massage and Wellness Clinic
415 17th St Suite 8
Oregon City, OR 97045
503-467-1561

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I hereby consent for my therapist to treat me with massage therapy for the above noted reasons, including such assessments, examinations and techniques which may be recommended by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand massage is not a substitute for a medical examination. I understand no assurances or guarantees have been made to me as to the results of this treatment. I understand that as with any treatment there may be risks and any risks have been explained to me and I assume responsibility for those risks.

I understand that the massage therapist must be fully aware of any existing medical conditions and that I have completed my health intake form accurately. I also agree to keep the therapist apprised of any new conditions.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other medical providers or third party payers.

Client signature:_____Date:_____

Insurance:_____

Insurance Phone #:_____

Insured's Name:_____Date of Birth:_____

Policy #_____Group #_____

Date of Injury:_____Work Related: ☐ yes ☐ no

Adjuster's name (If applicable):_____

Adjuster's Contact Information:_____