

INFORMED CONSENT FOR MASSAGE THERAPY

I hereby request and consent to the performance of therapeutic massage on me (or on the patient named below, for whom I am legally responsible) by the staff at Pacific Chiropractic & Wellness Center. I understand that in the practice of massage therapy there are extremely slight risks to treatment, including but not limited to fractures, dislocations and strains. I do not expect the licensed therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the licensed massage therapist to exercise judgment during the course of the procedure which he/she feels at the time, based on the facts then known, is in my best interests.

I have read, or have read to me, the above consent. By signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's name (please print) ----- Date-----

Signature of patient -----

INFORMED CONSENT FOR CHIROPRACTIC CARE OF A MINOR

Name of Responsible Party ----- Social Security Number -----:-----:-----

Relationship to Minor-----

Address or Responsible Party -----City----- State----- Zip-----

Home Phone----- Business Phone-----

Responsible Party Employed By-----

Employers Address-----City-----State-----Zip-----

I (We) being the parent or guardian of -----, a minor, the age of -----do hereby consent, authorize and request Pacific Chiropractic & Wellness Center licensed massage therapist to administer such treatment deemed advisable, necessary or requested on the above minor.

I (We) agree to hold him/her free and harmless from any claims or suits for damages or complications, which may result from such treatment.

Signature of parent or guardian----- Date-----

Signature of witness----- Date-----