***Massage Cupping Consent Form***

I understand massage is for the purpose of relaxation, stress relief, and relief of muscle tension. I agree to notify my therapist of any physical discomfort or draping issues during my session.

I understand that my therapist cannot treat, diagnose, and/or prescribe. If I am experiencing any major health problems I may need to see my doctor for diagnoses and/ or treatment.

If I choose to experience massage cupping (vacuum therapy) in my treatment, it has been explained to me that there is the possibility of a skin discoloration, or “cup kiss” appearing as tissue is released. I am aware that a “cup kiss” is not a bruise and that it will dissipate within a few hours to a few days. I understand the effects and after care recommendations.

Because massage is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist *updated* as to any changes in my medical profile and understand that there shall be no liability on the therapist’s part should I forget to do so.

I have the right of refusal any time in my appointment. I understand that I may be denied services if I have behaved inappropriately during the session or have consumed drugs or any intoxicating substances prior to my appointment.

By signing this release, I hereby waive and release Revelation Chiropractic & Chelsea Toon LMT from any and all liability, past, present, and future relating to massage therapy and bodywork.

Date - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_