Elemental Health LLC provides Massage Therapy and Bodywork which is intended to increase relaxation, reduce pain caused by muscle tension, improve range of motion limited by soft tissue tension, improve circulation and offer a positive experience of touch. This includes systems of activity applied ot the soft tissues of the human body for therapeutic, educational or relaxation purposes. This application may include:

1. Pressure, friction, stroking, rocking, kneading, percussion, or passive or active stretching within the normal anatomical range of movement.

2. Complementary methods, including the external application of water, heat, cold, lubricants and other topical preparations.

3. The use of mechanical devices that mimic or enhance actions that may possibly be done by the hands.

**Treatment Risk**: I understand that muscle soreness, tenderness or aches, transient bruising, feeling of lethargy, headache, feeling general malaise for up to 24 -48 hours following treatment is possible.

**No Guarantees**: I acknowledge that no assurance or guarantee has been made as a result of treatment. I acknowledge that with any treatment there can be risks and I assume those risks.

**Medical History**: I acknowledge and understand that my therapist must be fully aware of my existing medical conditions. I have completed my Client Information/Medical History form as provided and disclosed all known physical and medical conditions and all medications I am ingesting. I will keep the therapist updated on any changes in my physical or medical conditions, and medications, and I understand that there shall be no liability on the therapist’s part due to my failing to relay any pertinent information. The information I have provided is true and complete to the best of my knowledge.

**HIPAA**: I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers with my written consent or as provided by HIPAA regulations, which form I have read, understood, and signed.

**Consent to Treat**: I hereby consent for my therapist to treat me with massage therapy and bodywork for purposes reported in the Client Information/Medical History form. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that this treatment is not a substitute for medical treatment of medications, and that is recommended that I concurrently work with my Primary Care provider for any condition I may have. If I experience discomfort of any kind during or after treatment, I will communicate this immediately to the therapist. I understand I may withdraw my consent at any time and treatment will immediately be stopped.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_