Print Form

KAISER PERMANENTE®

HRN Label

Center for Complementary Medicine

CONSENT FORM FOR MASSAGE THERAPY

Massage therapy encourages healing by promoting the flow of blood, relieving tension, stimulating nerves, and stretching and loosening muscles to maintain elasticity. Massage therapy isn't meant to cure any serious or life-threatening medical disorders, rather provide some relief from the symptoms of anxiety, tension, depression, insomnia and stress, as well as back pain, headache, muscle pain, and some forms of chronic pain. It is frequently recommended for the treatment of minor sports injuries, and repetitive stress injuries, and for the enhancement of physical conditioning. Massage is an application of pressure and movement to the soft tissue of the body – the skin, muscles, tendons, ligaments, and fascia (the membrane surrounding muscles and muscle groups).

Possible Risks: Massage can aggravate existing swelling (edema). The pressure that massage exerts on the skin can be painful for someone who has a nerve injury.

I, _____ understand that it is my choice to receive this treatment and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made to me.

My signature indicates that I have read and fully understand the above information regarding the consent of this procedure. I have had the opportunity to ask questions about any matter which I did not understand, and I have received satisfactory explanations to my questions. My signature below authorizes this procedure.

_____ _____

Patient/Authorized Representative Signature | Relationship to Patient | Date

Practitioner Statement: The patient (or patient's representative) and I have discussed the procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands the procedure and consents to it.

_____ _____

Practitioner Signature | Practitioner printed name | Date

Cancellation Guidelines:
The staff of the Kaiser Permanente Centers for Complementary Medicine strives to provide excellent service to our patients. In order to do so, please give us a 24-hour notice of cancellation when you are unable to keep a scheduled appointment. We would be happy to reschedule your appointment for you. You could be charged a fee for failure to show for your appointment.

*Initials*_____

After-hours questions:
The Kaiser Permanente Centers for Complementary Medicine does not have after-hours availability. If you have general questions about our services, please call the main number for your ***preferred*** location and leave a message. Your call will be returned the next business day. If you are having medical symptoms that need immediate attention, please call your primary care physician or specialty care physician. If you believe it is an emergency, please call 911.

*Initials*_____

Acknowledgement of Financial Responsibility:
I understand that I am financially responsible to the Center for Complementary Medicine for services provided if not a covered benefit by my Kaiser Permanente plan. I am also responsible for payment of services at the Center for Complementary Medicine if my employment status has been altered or my insurance terminated.

*Initials*_____

If **Non-Kaiser Permanente member:** ***Primary Care Physician*** and Phone Number _____

Emergency Contact Name and Phone number: _____