Client Release and Permission to Treat for Elizabeth Bosse, LMT

Please read and initial:

_____ I understand the massage, craniosacral therapy, lymph drainage, or Reiki is for the purpose of stress reduction, emotional healing, relaxation of muscles, better circulation of lymph, cranio fluid, and energy throughout the body.

_____ I understand that massage, craniosacral therapy, lymph drainage, or Reiki does not diagnose illness, disease, or any other physical or mental disorders. In addition, the massage therapist does not prescribe medical treatments or pharmaceuticals.

_____It is understood that any illicit or sexually suggestive remarks or advances on the client's part will result in immediate termination of the massage session, and the client will be liable for payment of the full scheduled appointment.

_____ I understand that abdominal massage can be beneficial for certain issues. My therapist will explain and ask permission if this applies to this session.

_____I understand the working various muscles that attach the legs to the torso can be beneficial for certain issues. My therapist will ask explain and ask permission if this applies.

_____I understand that massage, craniosacral therapy, lymph drainage, or Reiki is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

_____Because the therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health. Further, I release the therapist from responsibility and liability for any adverse reactions resulting form disclosed and undisclosed conditions.

_____ *I give the massage therapist permission to work on my face.*

_____*I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from this practitioner.*

ClientSignature:_____Date:_____

Practitioner Signature:_____Date:_____

Consent to Treat a Minor

By my signature below, I hereby authorize Elizabeth Bosse, LMT to administer massage or craniosacral therapy to my child or dependent as they deem necessary. I understand that I, as the parent or guardian, must be in the room during the session.

Signature of Parent or Guardian:

_____Date:_____