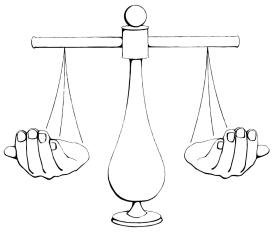

Michigan Clinical & Therapeutic Massage
2815 Michigan St., Suite B Grand Rapids, MI 49506
Phone: (616) 608-4094 Fax: (616) 608-4168
www.mi-ctm.com

Consent Form

Massage/Bodywork/Energy work/and Therapy Techniques

I understand that the massage, bodywork, energy work or other therapy techniques I receive are provided for a basic purpose of relaxation, relief or muscular tension, and/or to promote healing from within. If I experience any pain or discomfort during this or any session I will immediately inform the practitioner so the pressure may be adjusted to my level of comfort. I further understand that massage bodywork should not be misconstrued as a substitute for medical examination diagnosis, or treatment and that I should see a qualified medical clinic for any medical or physical ailment that I am aware of. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe, or treat any physical or mental illness and that anything said in the course of the session(s) given should not be construed as such. Because massage bodywork should not be performed under certain conditions, I affirm that I have stated all my known medical condition(s) and answered all questions honestly. I agree to keep the practitioner(s) updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.
I understand my records will be kept confidential and will not be released without my written consent. I understand the clinical and administrative staff may review my records for purposes of insurance reimbursement, quality improvement initiatives, and patient/client care. I understand that I may withdraw the consent at any time by contacting the staff at MCTM.

Client Signature _____ Date _____

Guardian Signature Authorizing Care _____ Date _____

Responsibility for Payment & Cancellation Policy

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself.
Furthermore, I understand that MCTM will prepare any reports and forms to assist me in making a collection from the insurance company. I understand that MCTM requires payment at the time of service.
I also understand that if I suspend or terminate my care, and fees for service rendered for me will be immediately due and payable. I also understand that appointments must be rescheduled or canceled **24 Hours in Advance** unless an emergency situation occurs.
A $45 fee will be billed for "No Show" appointments and a $25 fee will be charged for all returned checks.

Signature _____ Date _____