Restorative Medical Massage Therapy

524 South Ave East, Cranford NJ 07016
Tel: 908-688-5200

Consent to Evaluate and Treat

I do hereby consent to the evaluation and treatment by RMMT for Massage and Bodyworks Therapy treatment. I understand it is my right to accept or refuse treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that are obtained from such treatment. I understand that my therapist is a Licensed Massage and Bodyworks Therapist and is not a medical doctor. I also understand that my massage therapist recommends that I consult my medical doctor before starting any exercise program and from the diagnoses and treatment of any injury or pain and discomfort of unknown origin.

Please Print Clearly

Client Name: (Please PRINT):

_____

Date of Birth: _____

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Address:

_____

_____

City:_____

State: _____ **Zip:** _____

Home Phone: _____

Cell Phone: _____

Email (required):

_____

In Case of Emergency,
Contact: _____

Phone: _____

Relationship to Patient:

_____

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Referred By:_____

Please Check if you have any of the following conditions

_ Diabetes _ Cancer _ Inflammation\Swelling _ Arthritis

_ High Blood Pressure

_ Osteoporosis _ Recent Scar Tissue _ Recent Operation
_ Blood Clots _ Nut Allergy

_ Varicose Veins _ Skin Problem

_ Pregnant or think you might be
_Other, please specify:

_____

Fees and Policies

Price of treatment is dependent on the amount of time you are being seen or the package that has been purchases. Prices are subject to change at any time. Payment is due at the time of service.

Failure to give 24 hours' notice for a cancellation OR failure to show up for an appointment will result in a loss of a package session or a **$75.00 fee** (effective 1/9/2023), if patient does not have package sessions.

Assignment and Release

I, the undersigned, certify that I give consent to evaluation and treatment and understand the financial responsibility on my part. I hereby authorize RMMT to release all information necessary to secure payment of treatment. I authorize the use of this signature on all submissions.

Client Signature:

_____

Date: _____

FOR MINORS ONLY:

I, _____, parent/legal guardian of _____ have read the above information and give permission for my child to receive massage therapy from Restorative Medical Massage Therapy.

Parent/Guardian Signature:

_____

Date: _____

If any of our clients need aid in printing, interpreting or filling out the forms, we are happy to accommodate that at the time of the appointment. Please alert us in advance, and plan to arrive 15 minutes early.