Massage Cupping Gua Sha Consent/Release Form

* Required

1. **DATE** *

2. **FIRST and LAST NAME** *

3. **CLIENT AGREEMENT/CONTRACT FOR CARE: I hereby authorize Bonnie E Budde of Be Balanced Bodywork, LLC to perform Cupping Therapy and/or Gua Sha Therapy on me (or on the patient named below, for whom I am legally responsible). I recognize that there are potential risks involved with these therapies, which could include, but are not limited to the following: bruising, sore muscles, aches, and the possible temporary aggravation of my symptoms. I also recognize that while Cupping and Gua Sha provide the potential benefits of painless and drug free relief of my presenting condition and potential prevention of recurrences, there is no implicit guarantee of a cure from these therapeutic approaches.If I experience any pain or discomfort during the session, I will immediately inform my bodywork therapist so that the pressure may be adjusted to my level of comfort. I understand that I may stop the treatment if it uncomfortable to me.It has been explained to me, and I understand that Cupping Therapy and Gua Sha Therapy will leave bruise-like marks called petechiae that will last several days to several weeks depending on the severity of my condition. These areas of discoloration are typically not painful, but can on occasion be sore or itchy. I understand that cupping treatments can be a "detoxifying" treatment process and as a result, I may feel temporarily nauseous or unwell following a treatment. Drinking water and eating a light snack if you are hungry has been reported to relieve these symptoms quickly. In some cases, headaches and minor body aches may be experienced. I understand that Cupping and Gua Sha therapies should not be construed as a substitute for medical examination, diagnosis, or treatment, and that it is recommended that I see a physician for any physical or psychological ailment that I may have. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the bodywork therapist updated as to any changes in my medical profile during the sessions.I have carefully read and understand all the above information and by signing below, voluntarily consent to be treated with Cupping and Gua Sha by Bonnie E Budde of Be Balanced Bodywork, LLC.** *

   Mark only one oval.

   - ◯ Yes, I agree and understand the terms listed above.
   - ◯ No, I do not agree.

4. **Please type your full name as a signature.** *