KAREN McLEOD
MASSAGE THERAPY

Client Consent Form

Home Clinic
29 Shepherd Ave, West Melton
Phone: 03 3436224
Mobile: 027 2004161
Website: www.kmmt.co.nz

Name: _____ Date: _____

Address: _____

Phone: (Home) _____ (Work) _____ Mobile: _____

Email address: _____ Occupation: _____

Date of birth: _____ GP and/or other practitioner: _____

How did you hear about Karen McLeod Massage Therapy : _____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension.

If I experience any pain or discomfort during the sessions, I will immediately inform the practitioner so that the pressure and/or strokes can be adjusted to my level of comfort.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physisian, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware.

Agreement to pay
I understand I will be liable for the full cost of the massage service I have received and I undertake to pay any charges that I incur.

Your appointment time has been set aside for you, and you may cancel or reschedule without penalty anytime up to 24hours prior to your scheduled appointment. This allows other clients the chance to book. Less than 24 hours notice may result in a late cancellation charge of 50% of the session fee.
NO SHOWS will be charged the full price of the treatment session.

Massage session consent
I hereby give my consent to Karen McLeod Massage Therapyto massage me. I understand I have the right to decline any and all massages service offered to me at the time.

You may experience mild discomfort, headaches or tiredness after the massage. This is normal cleansing response to flushing waste products from muscles that have been tense. Please contact me if you have any severe or ongoing effects after the massage. Please consult your health practitioner if you have medical conditions that persist.

Please address any concerns or complaints firstly to this practitioner, or if not resolved to The Health and Disabilities Commission, P.O.Box 1791, Auckland.

Signature: _____ Date: _____

If under 18 years of age, please give details of parents or guardian:

Name: _____ Phone: _____ (Work) _____ Mobile: _____

Address (if different to above): _____