



Armonia Health LLC
1911 Hillandale Road Suite 1230 Durham, NC 27705
(919) 251-9698
www.armoniahealth.com

Armonia Health LLC Consent Form for Massage

Please note for those receiving cupping therapy as part of their massage, due to the nature of the cups pulling toxins and stagnant blood to the surface of the skin, this may cause a ring, slight bruising, or circle of discoloration to appear on the skin. These marks vary from person to person and generally dissipate within a week of treatment. This is a normal reaction and part of the healing process.

HIPAA regulations require all practitioners obtain a signed release form from their patient/client before taking any information about them. Clients should receive a copy of the form they signed (upon request) and the practitioner maintains a copy for their records. I give my permission, for my practitioner, to take notes including health history/ medical and /or personal information I choose to disclose to him/her if he/she deems necessary. I understand this information may be shared under legal obligations or with another medical professional or health care provider to enhance my quality of care. Armonia Health LLC works with an integrative model, so my file can be shared if I see another practitioner at this practice.

Our office requires **48 hours** notice if you need to cancel or change your appointment; less than 24 hours of notice of cancellation will incur a fee of 100% of the session fee. We appreciate your consideration and respect with this matter. Please check our website or call our office to inquire about current massage rates. Current session rates, payable in cash, check, or credit card to Armonia Health LLC upon service

Client Signature: _____ Date: _____

Printed name: _____

Parent/Guardian signature: _____

Printed name: _____