Armonía Health LLC
(919) 251-9698 | (919) 225-2340
www.armoniahealth.com
1911 Hillandale Road Suite 1230 Durham, NC 27705

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 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 the practitioner if the practitioner 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. Armonía Health LLC works with a cooperative model, so my file is shared if I see another practitioner at this practice and my signature on this form gives permission to the practitioners at Armonía Health LLC to speak to each other.

I understand Armonía Health LLC requires **48-hours** notice if I need to cancel or change my appointment. If I cancel less than 24-hours before my appointment or do not come to the appointment, I understand I will be charged 100% of the session fee. I understand if I arrive 30 minutes late to my appointment, my session will not be extended, and I will be charged the full session fee. I know I may cancel or change my appointment using the online scheduling system or by calling and leaving a message on the Armonía Health voice messaging system.

Current massage rates are posted on the Armonía Health LLC website and in the office. Massage session fees are payable in cash, check, or credit card to Armonía Health LLC upon service.

Client Signature: _____Date: _____

Printed name: _____

Parent/Guardian signature: _____

Printed name: _____