MANCHESTER-BEDFORD MYOSKELETAL
A New Hampshire Limited Liability Company

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Veteran Informed Consent for Therapeutic Massage/Myoskeletal Therapy

I, _____, (patient) understand that massage therapy provided by ***Manchester-Bedford Myoskeletal LLC*** (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

_____

_____

The general benefits of massage, possible massage contraindications, and treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. Certain appliances and equipment typically used in the treatment of soft tissue with the scope of standard massage practice may be used during my treatment with my permission. I understand that any muscle retraining or strengthening exercises given by the therapist are only suggested and not prescribed.

I have informed the massage therapist of all my known physical conditions, medical conditions, and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the treatment can be adjusted appropriately.

I have received a copy of the therapist's policies; I understand them and agree to abide by them.

I understand and agree that all clinic notes and records for VA-referred treatments at this facility will be entered into any system required by the Veterans Administration provider contract or referral authorization. I further understand these notes and records may be seen by any VA physician or VA Community Care Network Provider to whom access to your records is approved.

Sign: _____ Date: _____