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# INFORMED CONSENT TO MASSAGE THERAPY TREATMENT
# RELEASE OF LIABILITY AND DATA PRIVACY

- I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Bermuda Massage Therapy Association.

- I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

- I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

- I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

- I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

- I have read the above noted consent and I have had the opportunity to question the contents and my therapy. I will indemnify and hold harmless, the owner and the operator of Nathi's Tuina Massage Fusion, together with their officers, directors, shareholders, employees, agents, and representatives and all successors and/or assigns from and against any and all actions, cost, claims, losses, expenses, in any manner resulting from your use of the Services.
- I further understand it is my sole responsibility to determine my suitability and personal knowledge on the use of the Services.
- I agree that these terms and conditions shall apply to my current and future use of the Services.
- I hereby agree that any dispute or claim that arises out of or is related to use of the Services is subject to the law of Bermuda and the exclusive jurisdiction of the courts of Bermuda.
- Nathi's Tuina Massage Fusion will retain your personal data and preferences on its records to provide you with a more tailored service for your future services. Should you prefer NTMF not to use your data for this purpose, please tick the box here ☐
- NTMF will use your personal data to contact you regarding news and promotional offers. If you do not want NTMF to contact you for this purpose, please tick the box here ☐
- You acknowledge that you have read this Release of Liability and Data Privacy statement carefully and understand its meaning and you agree to be bound by this Release of Liability and Data Privacy statement.

Signed ______________________________ Date ______________________________

Patient Name ______________________________ Signature of Patient/Guardian ______________________________

**HEALTH HISTORY FORM – MINIMUM REQUIREMENTS**
PRIVATE AND CONFIDENTIAL

**Name:** ________________________________________ **Date of initial visit:** ________________

**Address:** ______________________________________ **Phone number:** ____________________

**Date of birth:** ______________________ **Referred by:** _________________________________

**Physician name:** _______________________________ **Allergies:** ________________________

**Sports & activities:** ____________________________________________________________________

**Current medications**: ____________________________________________________________________

**Are you under medical care for any of the following: (circle)** Please indicate which of the following applies to you. The information obtained will be used to help us determine how to best tailor our services and will be treated as private and confidential.

| | | |
|---|---|---|
| heart conditions | high/low blood pressure | fainting or dizziness |
| varicose veins | phlebitis/circulatory problems | headaches or migraine |
| neck injury | back injury | jaw or ear pain |
| osteoporosis | rheumatoid arthritis | osteoarthritis |
| cancer | kidney disease | skin conditions |
| diabetes | asthma/respiratory | fibromyalgia |
| Crohn's disease | pelvic inflammatory disease | epilepsy |
| nervous disorders | whiplash | other: |

**Have you received care from any of the following: (circle)**

physiotherapist chiropractor massage therapist naturopath

other: ____________________________________________________________________________

**Reason for treatment:** ______________________________________________________________

**Number/duration of treatments:** ______________________________________________________

**Have you had surgery in the past? Y N** If yes, for what? ______________________________

**Have you had any fractures/sprains in the past? Y N** If yes, where? ____________________

**Have you had any serious illnesses in the past? Y N** If yes, what? _____________________

**Did the current injury result from a motor vehicle accident or workplace injury? Y N**

**Have you had any of the following regarding your current condition: (circle)**

physician's examination x-ray other diagnostic tests

**What relieves your pain?** ____________________________________________________________

**What aggravates your pain?** __________________________________________________________

**Signature of Patient (or Guardian):** ___________________________________________________