



Consent and Schedule Agreement

I hereby authorize At Ease Massage Therapy to assist me in my physical goals, -that are ultimately decided on by me- within their scope of practice, as Licensed Massage Therapists, as defined by the governing body in the state of Oregon. I understand that some level of discomfort may be experienced during and after a massage session, but that those employed by At Ease Massage Therapy have only my best health and well-being in mind, and further that it is at my discretion how much discomfort is tolerable for me. I also understand that at any time before or during a massage I have the right to stop the treatment/session at any time for any reason, and that my massage therapist also reserves the right to stop the treatment/session at any time as well.

I give consent to those employed by At Ease Massage Therapy to discuss my case with the other health care providers, doctors and/or wellness advocates that are treating/assisting me in my path to physical and emotional wellness. I understand that my massage therapist will use extreme care and discretion when speaking with other providers to ensure that only matters within their scope of practice and with my benefit and well-being in mind will be discussed in a "closed door" manner. I further understand that this will only be done so that my massage therapist and my other wellness providers can best benefit me within their respective scopes of practice by obtain a broader understanding of my total health and wellness.

I hereby give permission to begin the massage session(s).

Printed Name: _____ Signature: _____ Date: _____

Signature of legal guardian (if client-patient is under 18 years old): _____

I understand that all appointment cancellations must be given at least 24 hours in advance via direct telephone call to At Ease Massage Therapy, email to At Ease Massage Therapy through one of the direct email accounts (as listed on all At Ease Massage Therapy business cards), or face-to-face. I further understand that At Ease Massage Therapy reserves the right to charge me a \$30.00 cancellation fee for any cancelations given less than 24 hours before the said appointment begins. I assume responsibility that I, not my insurer or any other third party payer or representative, will be responsible for making the cancellation penalty payment not more than 30 calendar days from the time of cancellation or the date the bill is issued, which ever comes first.

Printed Name: _____ Signature: _____ Date: _____

Signature of legal guardian (if client-patient is under 18 years old): _____