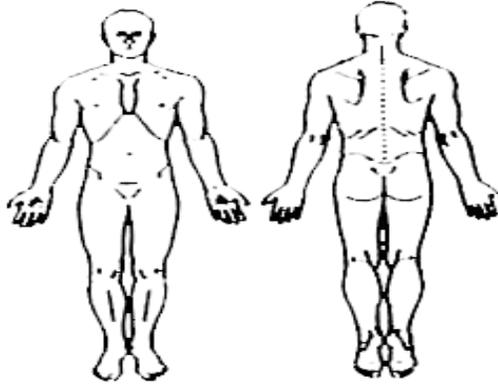Please indicate on the diagrams below the areas in which you are feeling pain

Contract for Care

I agree to participate fully as a member of my Health Care Team. I will make sound choices regarding my treatment plan based on the information provided by my Massage Therapist and other members of my Health Care Team. I agree to participate in the self-care program that we select. I promise to inform my Health Care Team any time I feel my well-being is threatened or compromised. I expect my Massage Therapist to provide safe and effective treatment.

Concent for Care

It is my choice to receive masage therapy, and I give consent to receive treatment. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for medical treatment, examination and /or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

AUTHORIZATION:

I hereby authorize Gary L. Wass Massage to furnish the above information
to insurance carriers and irrevocably assign to Gary Wass all payments for massage
therapy services rendered. I understand that any benefits quoted by my insurance
company are not a guarantee of payment. I understand that I am financially responsible
for all denied claims or claims not paid by the insurance company.

I understand that full payment is due at the time of treatment.
I agree to give 24 hours notice of cancelation for any appointment I have scheduled. If less
than 24 hours notice is given, I agree to pay a $40 fee. If I miss or no-show an appointment
I agree to pay the full price for the missed appointment. Cases of extreme emergency are
considered exceptions.

Patient Name (Please Print)	Date

Patient Signature	Date

Responsible Party Signature (if patient is a minor, parent signature)	Date