Align Massage + Wellness, LLC

Cupping Therapy Release Form

- I understand that all treatments at this office are therapeutic in nature. I agree to communicate to the therapist any physical discomfort during the session.
- Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.
- It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my intake form, to avoid any complications.
- **I am not taking blood thinners, experiencing a fever, cancer, had recent surgery, have hemophilia or bleeding / clotting disorders, diabetes, abnormal blood pressure, nor am I currently pregnant. If I am, I understand that I will tell the therapist before treatment of Cupping Therapy.**
- It has also been explained to me that there is the possibility of discolorations or bruise-like markings that can occur from breaking up myofascial congestion or stagnation in my body.
- I further understand that the discolorations or bruise-like markings will dissipate from a few hours to as long as 2 weeks in some cases in relation to my after-care activities.
- I understand that the first time I experience Cupping, my body's immune system can temporarily react to this release as it might with the flu- producing effects like nausea, headache, and aches that will subside in time with rest and water. Water helps to dilute the intensity of the release.
- I agree to disclose if my medical health history would happen to change during the time period of receiving Cupping Therapy.
- I have read all of the above disclaimer and I agree that I am not currently experiencing any of the contraindications. I have had the opportunity to ask any questions about this treatment, and by signing below I agree to release Align Massage + Wellness, LLC and its therapists from any liability in connection with receiving Cupping treatments.

Name:_____ Date:_____

Signature:_____