PROACTIVE MASSAGE+BODYWORK

Cupping Therapy Consent and Release Form

Cupping Therapy applies negative pressure to the skin using plastic, glass, or silicone cups. The suction created stimulates and increases blood flow, which can help relieve joint and muscle pain, reduce inflammation, accelerate recovery, increase the function of the lymphatic and circulatory systems, and increase overall relaxation and well-being. By creating this negative pressure, cupping lifts and releases congested connective tissue (by aligning the collagen fibers), loosens adhesions, and helps re-oxygenate tissues that have been injured while increasing healthy circulation to the targeted area.

Precautions and Contraindications

- ☐ Deep Vein Thrombosis (blood clots)
- ☐ Autoimmune diseases, i.e., Lupus, MS, Parkinson's, etc.
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Lymphedema
- ☐ Fever
- ☐ Cancer
- ☐ Taking Blood Thinners
- ☐ Injections/Patches: Botox, Steroids, Insulin, Birth Control, Nicotine, Etc.
- ☐ Chronic Illness Not mentioned above (please list): _____
- ☐ Medications currently taking (please list): _____ _____

Note: *We cannot evaluate your medical conditions, medications, allergies, or surgeries with regards to the safety of Cupping Therapy. If you have any questions about the status of your health, please consult your physician before engaging in any service.*

Please read and initial on each line

_____I understand that the vacuum formed by cupping may result in marks being left on my body. I understand that these marks should fade within a few hours to two weeks.

_____I understand that as cupping treatments continue, the discoloration of these marks will be less obvious.

_____I understand cupping marks should not be tender to the touch, and no pain should be felt.

_____I understand if I am receiving facial cupping for TMJ, headaches, sinusitis, Bell's palsy, trigeminal neuralgia, etc.; in order to treat these conditions most effectively, cups may be retained in one place. Although this is not the standard, as we try not to leave cups stationary on the face, depending on my condition and skin type, my face may acquire cupping marks.

_____I agree to inform my practitioner if I have any of the conditions listed above and to list any medication I am currently taking.

I, _____(Name of Client), consent to allowing the Cupping Practitioner to perform *Cupping Therapy*. I understand the benefits, side effects, contraindications, and possibility of skin marks as part of *Cupping Therapy* and will not hold the practitioner responsible.

_____ _____

Signature of Client Date

Proactive Massage + Bodywork, LLC | NPI #1952948481
9225 Atlee Road | Suite 5103 | Mechanicsville, VA 23116
Phone: 804-559-7990 | info@proactiverva.com

Waiver of Liability and Hold Harmless Agreement;

1. In consideration for using the services, therapy, and machines (hereinafter referred to as “Treatment”), I hereby release, waive, discharge, and hold harmless Proactive Massage + Bodywork, LLC, its officers, servants, agents, employees, and volunteers (hereinafter referred to as "Releasees") from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, or injury that may be sustained by any person, while using the equipment, or due to the use of the Treatment.
2. I hereby confirm that no warranty, guarantee, or other assurance has been made to me covering the results of the Treatment, and I hereby relieve them and hold them harmless from all liabilities for injury or damage that may occur to me. I fully understand the administration of the process, including possible adverse reactions, side effects, or other possible complications. It is understood that this consent is being given in advance of any administration of the process and is being given by me voluntarily to use the Treatment.
3. I am fully aware of the risks and hazards connected with the use of the treatment, including the risk of physical injury or disability as the result of such injury, and I am voluntarily participating in said Treatment usage and entering the above-named premises to engage in such usage. I voluntarily assume full responsibility for any risks of loss, property damage, or personal injury that may be sustained, or for any loss or damage to property as a result of being engaged in such an activity. I further hereby agree to indemnify and hold harmless the Releasees from any loss, liability, damage, or costs that may incur due to my use of the Treatment. I understand that the Proactive Massage + Bodywork, LLC therapists are not qualified to diagnose or perform medical procedures, and nothing said during the Treatment session should be construed as such.
4. Prior to using the Treatment, I affirm that I have stated all my known medical conditions and answered all questions honestly. I further agree to update Proactive Massage + Bodywork, LLC, as to any changes in my medical profile that may impact or limit my ability to utilize the Treatment and agree to defend and indemnify Proactive Massage + Bodywork, LLC and the above-named releases for failure to do so.

My Signature Below Constitutes My Acknowledgment That;

(1) I have read, understood, and fully agreed to the foregoing consent; (2) the proposed Treatment process has been satisfactorily explained to me, and I have all the information I desire; and (3) I hereby give my authorization and consent. This consent shall stand as long as I use the Treatment at the location now and in the future. I have read the instructions for proper use of the facilities and do so at my own risk. I hereby release the owners, operators, franchisers, or manufacturers from any damage or harm that I might incur due to the use of the Treatments or facilities.
In signing this release, I acknowledge and represent that I have read and understand the foregoing Waiver of Liability and Hold Harmless Agreements, that I am at least eighteen (18) years of age and fully competent, and that I execute this release for full, adequate, and complete consideration, fully intending to be bound by the same.
Furthermore, I agree that I will comply with all instructions on the use of the Treatment and that I am using these services at my own risk. I agree to use all sessions within the terms of the contract dates and understand that refunds are not given on unused portions of purchased packages.

Client’s Name (Please Print)	Client’s Signature	Date

Parental Consent Form For Minors Under The Age of 18;

If the client is under 18 years of age, parental consent is required. Please complete the form below for the consent of a minor;
I, _____(name of parent or legal guardian), acknowledge that I have read and understand the Proactive Massage + Bodywork, LLC Waiver of Liability and Hold Harmless Agreements, as well as the contraindications and waiver of risk. My son or daughter, _____(name of the minor), has also read the Waiver of Liability and Hold Harmless Agreements and agreed to the contraindications and waiver of risk. I give consent on behalf of my minor to voluntarily undergo Treatment.

Parent/Guardian Name (Please Print)	Parent/Guardian Signature	Date
Minor’s Name (Please Print)	Minor's Signature	Date