Massage Cupping Liability Release Form

_____ I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.

_____ Information has been provided to me about Massage Cupping. 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 Massage Cupping. I have fully disclosed all health factors to my therapist, including those not mentioned on my Client Intake Form, to avoid any complications.

_____ It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body. They are referred to as 'healing marks'.

_____ I also understand that this reaction is not bruising, but is due to cellular debris, pathogenic factors and toxins being drawn to the surface to be clear away by my circulatory systems.

_____ I further understand that the discolorations will dissipate from a few hours to as long as 3 weeks in some cases and 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 flu-like effects like nausea, headache, aches, that will subside in time with rest and water. Water helps to dilute the intensity of the release.

_____ I understand that Massage Cupping should not be combined with aggressive exfoliation, 4 hours shaving, after sunburn or when I'm hungry or thirsty.

_____ I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 4 - 6 hours. I understand that exposure to such extremes can produce undesirable effects and I should avoid such situations.

_____ I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean water.

I _____ agree to allow Liz Marlowe, LMT to perform Massage Cupping. I also agree that I have read, understand and will follow all of the information stated above and will not hold the her responsible.

Date_____ Signature of Client _____

Print Name _____

Date_____ Signature of Practitioner _____

Print Name _____