Massage-Wellness

Consent to Treat During Pregnancy

By signing below I hereby authorize Massage Wellness and their licensed massage therapy staff to administer massage therapy as deemed necessary to my patient, _____

(Print name of patient)

Special instructions (if any):_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Physician: _____

Printed Name of Physician: _____

Dated on the _____ (day) of _____ (month), _____ (year)

3800 South Ocean Drive # G5
Hollywood, Florida 33019