Soulstice, Ltd.
Innovators of Peri-operative Therapy

Client Policies
Please initial where indicated, then sign and date below.

These massage treatments are to encourage and support you, the client, whether it be during your post-operative rehabilitation or general health maintenance. It is your responsibility to communicate your individual and specific needs. Therefore, at any time, you need to communicate any sort of discomfort, including: **pain** perception; **pressure** of touch; **music** selection; **temperature** of room; etc.

I understand it is my responsibility to communicate my individual needs to my massage therapist. ____

It is your responsibility, as the client, to communicate any and all aspects of your health history that may directly impact the massage treatment. Soulstice and your designated massage therapist will safeguard the confidentiality of all client information, unless disclosure is required by law, court order, or is absolutely necessary for the protection of the public.

I agree that all provided health history is true and correct, both physiologically and psychologically. ____

Soulstice and your designated massage therapist have a sincere commitment to provide the highest quality of care to those that seek their professional services. They will conduct their business and professional activities with honesty and integrity, and respect the inherent worth of all humans. Soulstice and your designated massage therapist will respect your boundaries with regard to privacy, disclosure, exposure, emotional expression, beliefs, and your reasonable expectations of professional behavior. Your practitioner will respect your autonomy. Additionally, please know that you may request an eyewitness to be present during treatment.

*I understand my right to an eyewitness, and I **request** ____ or **decline** ____ to have one present.*

Your Soulstice therapist strictly adheres to the Code of Ethics as provided by the National Certification Board for Therapeutic Massage and Bodywork. Client and therapist will refrain, under all circumstances, from initiating or engaging in any sexual conduct, sexual activities, or sexualizing behavior involving a client or therapist, even if the client attempts to sexualize the relationship.

I agree to the professional conduct and ethical boundaries of a professional relationship with my designated massage therapist. ____

Breast massage often requires the massage therapist to undrape the chest region in order to provide therapeutic treatment, including post-surgical rehabilitation. Your therapist recognizes the sensitive nature of a woman's chest region. Utmost care and concern will be taken in order to honor a client's modesty. It is your responsibility, as the client, to communicate to the therapist if you are uncomfortable with any portion of the therapeutic treatment.

*I understand the therapeutic intent of breast massage and I **consent** ____ or **decline** ____ to treatment.*

Please let us know if you would like a copy of this document for your records.

Client

Signature _____

Date _____

Massage Therapist

Signature _____

Date _____

3470 South Sherman Street, Suite 3, Englewood, CO 80113
(303) 628-0205 SoulsticeWellness.com