Informed Consent for Fascial Stretch Therapy

I herby consent to the performance of Fascial Stretch Therapy by the therapist named below. FST in general provides benefits including the relief of non-medical aches, pains, stiffness, tightness and immobility, as well as improvement in athletic performance, posture, range of motion, flexibility and strength. I understand that FST practitioners do not diagnose illness or disease, perform any spinal manipulations, nor prescribe any medical treatments. I accept that FST promises no permanent results nor will it cure any health problems.

The therapist must be aware of all health conditions due to certain contraindications or cautions. I have disclosed all such conditions, and will update any changes to my health.

If at any time during the session you are uncomfortable for any reason, you shall immediately say so.

Cancellation Policy

In order to provide clients with the full attention they deserve and minimize disruptions to the schedule,

24 hours notice to change, cancel and /or reschedule appointments is required.

If 24 hours is not provided, the client will be responsible to pay for the full price of the scheduled appointment.

All information will be kept confidential and under lock and key.

I have read and agree with above information. If I have any questions or concerns, I will let the therapist know right away.

Print Name: _____

Signature: _____ Date: _____

Therapist: _____ Date: _____