



Sacred Grove Holistic Healing and Learning Center

1008 Winscott Road; Suite A O: (469) 309-8243
David Peter Armentano LMT, MTI, CE Provider

Consent to receive Gua Sha/Cupping Massage

I understand that Gua Sha/Cupping Massage is designed to alleviate pain and improve mobility in the soft tissues. I have been informed that it causes a bruising as part of its function.

Please Check One:

_____ I **Do** understand and consent to Gua Sha/Cupping Massage with the full knowledge of its side effects (Bruising).

_____ I **DO NOT** consent to Gua Sha/Cupping Massage with the full knowledge of its side effects (Bruising).

The procedure has been explained to me for Gua Sha/Cupping massage. I understand my therapist will ask me for verbal consent to this procedure during the session and that I have the right to terminate this consent at any time, for any reason, and if I do so during a session the session will end, and I will be billed for the service time rendered.

Signature of Client: _____ **Date:** _____

Signature of Therapist: _____