Within Balance
Massage Therapy Surrounding Birth

Acknowledgement and Consent for Breast Massage

Your consent will be acknowledging and agreeing to the following:

- I understand that the massage therapist will assess my tissues, but does not diagnose illness, disease, or any other physical disorder.
- I understand that the massage therapist does not prescribe or perform medical treatment, nor spinal manipulation.
- I understand that massage therapy is not a substitute for a medical examination or treatment with my healthcare provider.
- I understand that it is my responsibility to report changes in my health and give feedback to the massage therapist so I can work together with them as a team to optimize my experience.
- I understand that if I feel uncomfortable for any reason during the massage therapy session, I can stop and discontinue the treatment at any time.
- I understand that if I prefer, I can have a witness in the room with me during my massage therapy session. I understand that I am responsible to provide this person and will coordinate with the massage therapist.

Full chest and breast massage that includes the nipples and areolae: treatment of the breast tissue is performed to increase breast health awareness, relieve congestion and edema in the upper chest and breast, ease tightness due to scar formation from surgery, increase range of motion, prevent stagnation of fluid, alleviate breast symptoms of Premenstrual syndrome (PMS), enhance milk flow and production for breastfeeding, ease discomforts of pregnancy and breastfeeding, reduce breast and nipple pain, improve respiration, increase flow of blood and lymph fluid throughout the breast tissue, and relax the fascia. All people have breast tissue, and under current regulations, must consent for massage to be performed on this region. Please select your preference:

- [ ] I consent to have this area treated over clothes or a drape
- [ ] I consent to have this area treated undraped (skin contact)

Client's Name ______________________________ Date ______________

Signature ______________________________

Therapist's Name ______________________________ Date ______________

Signature ______________________________

Deanne Falzone, MSEd, ICCE, LMT
deanne@withinbalance.org • 312.618.3614 • www.withinbalance.org