PATIENT'S INFORMED CONSENT FOR PHYSICAL THERAPY, MASSAGE THERAPY AND CHIROPRACTIC CARE SERVICES

To promote the health and wellness of individuals, the practices of physical therapy, massage therapy and chiropractic care utilize corrective treatments, administered by a variety of methods including, but not limited to, the use of physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and resistive exercise, to treat disease, injury and disability through evaluation, treatment planning, treatment administration, and instruction services (collectively "Services"). Mizokami Advanced Circulatory Sports Therapy ("Mizokami ACSL") maintains facilities to assist physical therapists, massage therapists and chiropractors in the performance of various Services. These Services may all involve risks of unsuccessful results or complications from both known and unforeseen causes, and, therefore, no warranty or guaranty is made as to the result of any Service. Patients have the right to be informed of risks associated with any Service prior to its administration as well as the nature and purpose of the Service, and any alternative method of Service, and this form is not a substitute for the explanations which shall be provided to each patient by his or her physical therapist(s), massage therapist(s) and/or chiropractor(s).

In addition, Mizokami-Advanced Circulatory Sports Lymphatic (MACSL) massage therapy increases lymph flow, improves circulation and promotes the body's own elimination of toxins (debris). The unique technique integrates cross fiber and sports massage techniques, and is specially tailored to an individual's needs. This technique may include the treatment, remission, and prevention of breast cancer and other types of cancer, which necessarily involves massage of the breasts and the breast area.

Performance of Proposed Services

Patients have the right to consent to or refuse any proposed Service at any time prior to its performance. Due to the nature of Services performed, a patient may be asked to disrobe to allow a physical therapist, massage therapist and/or chiropractor to administer treatment, in which case, prior to performance, the physical therapist, massage therapist and/or chiropractor shall inform the patient in advance and obtain the patient's consent. **In addition, the MACSL massage therapy may necessarily involve the massage of the Patient's breasts and surrounding areas due to the location of the breast lymph system.** If the Patient is uncomfortable with the physical therapist, massage therapist and/or chiropractor touching and/or massaging the breasts and the surrounding areas, then the Patient should inform the physical therapist, massage therapist and/or chiropractor prior to the session. If the Patient becomes uncomfortable at any time during the breast massage, then the Patient should so inform the physical therapist, massage therapist and/or chiropractor immediately. To maximize the Service's efficacy, patients agree to participate in and take seriously those Services to which a physical therapist, massage therapist and/or chiropractor proposes and patient subsequently consents to being performed.

Acknowledgement of Authorization

Your signature below constitutes your acknowledgement (1) that you have read and agree to the foregoing; (2) that the Service described below has been adequately explained to you by your physical therapist, massage therapist and/or chiropractor and that you have received all of the information you desire concerning this Service; (3) that you authorize and give your informed consent to the performance of the Service; (4) that if the Service involves the massage of the breasts and/or surrounding areas you have consented to this procedure; and (5) you have consulted with a physician in respect to any preexisting medical condition to ensure the Service described below is appropriate to participate in.

Service to Be Performed: _____

_____

_____

_____

Assigned Physical therapist, Massage therapist and/or Chiropractor:

_____

THE PARTIES HAVE READ AND UNDERSTOOD THE FOREGOING TERMS AND AGREE TO THEM AS OF THE DATE BELOW.

Dated: _____ By: _____

Print Name: _____
[PATIENT OR AUTHORIZED REPRESENTATIVE]

Dated: _____ By: _____

Print Name: _____
[AGENT OF MIZOKAMI ACSL]