



# Winston Rolfig® Structural Integration

*Experience your natural state of being*

Melanie Dail, Certified Rolfer™

## Consent to Treatment

I understand that Rolfig Structural Integration is provided to improve postural balance and alignment; and that this process may reduce chronic soft tissue pain and tension.

I am aware that physical manipulation of my body's soft tissues (muscle, tendon, nerve, bone) and movement in the form of walking, reaching, bending, etc. are part of this treatment. If I experience any pain or discomfort during session(s), I will inform my Rolfer so that pressure and/or manipulation may be adjusted to my level of comfort.

I understand that Rolfig SI is not a substitute for medical treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I may have. I agree to receive Rolfig Structural Integration from Melanie Dail, Certified Rolfer and will inform her of any changes in my medical profile.

Client Name Printed: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_

**Consent to Treatment of Minor:** By my signature below, I hereby authorize Melanie Dail to administer massage, Rolfig SI, or somatic bodywork techniques to my child or dependent named: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

**Release of Information:** By my signature below, I hereby authorize Melanie Dail to release information regarding my bodywork treatments and recommendations of said Rolfer to my physician or insurance company named: \_\_\_\_\_

Contact Info: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Cancellation Policy

Barring unforeseen emergencies, I agree to give 24 hours notice of cancellations. I also agree to pay for any missed appointment in full when notice has not been provided.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_