# Massage Cupping/MediCupping™ Therapy Release Form

I understand that all treatments at this facility are therapeutic in nature. I agree to notify the therapist of any physical discomfort or draping issues during the session.

This facility has provided me with information on Massage Cupping/MediCupping™ therapy. If I choose to experience this therapy in my treatment, I understand the effects and after-care recommendations. It has been explained to me that there is the possibility of a skin discoloration, or "cup kisses," appearing as tissue is released. I am aware that a "cup kiss" is not a bruise and that it will dissipate within a few hours to a few days.

This facility and the therapist will not be held liable for indications that arise during or after the treatment, and I agree to notify the therapist if there is any discomfort during a session. I have stated all relevant physical conditions and will inform the therapist of any changes in my health.

Signature _____ Date _____