INFORMED CONSENT TO MASSAGE THERAPY

I understand that the Registered Massage Therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario (CMTO). I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I understand that massage therapy is not a substitute for a medical examination. It is recommended that I visit my personal physician for any ailments that I may be experiencing.

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and have disclosed to the therapist all of the medical conditions affecting me. The information I have provided is true and complete to the best of my knowledge. I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third-party payers as needed.

Cancellation Policy:
Our policy is simple. If you do not show up for your scheduled appointment, and you have not notified your therapist at least 24 hours in advance, you are subject to the fee of the full cost of treatment. When you book an appointment with us, that time is allotted for you—and only you. We do our best to always be ready for you when you arrive, and in return we ask that you show up to your appointment on time. Please understand that massage therapists only get paid when they deliver treatment. Consequently, missed appointments are costly and prevent us from providing treatment to other patients.
I understand the cancellation policy, and that I must provide at least 24 hours notice if I am to cancel my appointment. I understand I may be charged a fee for the missed appointment if proper cancellation notification is not provided to the clinic.
Note: We recognize that no one is perfect and there are circumstances that are out of your control (sudden illness, family emergencies, etc.); therefore your therapist may make an exception to the above policies on those rare occasions.

I have read the above noted consent and I have had the opportunity to question the contexts and my therapy. I consent to treatment and intend this consent to cover my treatment discussed with me and such additional information proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that I may withdraw my consent at any time, and treatment can be stopped.

Patient Name: _____ Signature of Patient or Guardian:_____
Date Signed:_____ ____ Therapist:_____