INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Massage Therapist is providing Massage Therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario.

I hereby consent for the Massage Therapist to treat me with Massage Therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by the Massage Therapist.

I acknowledge that the Massage Therapist is not a Physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that the Massage Therapy is not a substitute for a medical examination. It is recommended that I attend 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 Massage Therapy treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me, and I assume those stated risks.

I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed the Medical/Health History form, in its entirety, as provided by the Massage Therapist and have disclosed to the Massage Therapist all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize the Massage Therapist to release or obtain information pertaining to me condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read and understand the above and have had the opportunity to question the contents and the therapeutic choices. By signing this form I am consenting to the treatment and intend this consent to cover the treatment discussed with me and such additional treatment(s) as proposed by the Massage Therapist as pertaining to the physical condition(s) for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Client Name (Print): ____

Client Signature: ____

Witness Name (Initial): ______________________________________

Date Signed: ____