

Consent for Massage Therapy

In Accordance with the Standards of Practice and the Code of Ethics of the College of Massage Therapists of Ontario:

- I have the opportunity to discuss the nature and purpose of the proposed assessment/reassessment/treatment/treatment plan with the Massage Therapist.
- I am aware that I may discontinue the assessment/reassessment/treatment/treatment plan at any time at my discretion.
- I understand that there are possible side effects/risks to the treatment including, but not limited to: light-headedness, muscle aches and pains, bruising, swelling, redness and/or other skin reactions.
- I understand the fee structure and accept full responsibility for prompt payment. I understand and agree that if I am late for my appointment, I will receive the remainder of the appointment time but will be responsible for the full payment of the scheduled appointment. **Cancellation policy:** I also acknowledge the policy that appointments cancelled with less than 24 hour notice or missed will be subject to a \$50.00 charge.

Specific areas of the body that may be treated include

- Upper back ● Mid back ● Lower back ● Head ● Neck and shoulders ● Arms
- Wrists and hands ● Legs and feet ● Inner Thighs ● Buttocks (gluteal muscles)
- Chest wall musculature

When the treatments of sensitive areas such as gluteal, inner thigh, or chest wall are indicated during the course of treatment, it is especially important that you, the client, fully understand the nature and purpose of this treatment. If you have any questions at any time, please do not hesitate to ask. A record of this consent will be kept in your confidential client file.

I have read the above information and have had the opportunity to ask questions that I have about the content. By signing below I give my consent to the Massage Therapist to proceed with assessment/reassessment/treatment as presented to me. I intend this consent to cover the entire course of treatment for my present condition and for any ongoing issues that I may present with. I understand that I may alter or withdraw my consent at any time.

Patient's Name _____

Signature of Patient (parent or guardian) _____

Date Signed _____

Witness: _____ Date: _____

Privacy Information Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to me. They are all trained in the appropriate uses and protection of your information.

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protocols.
- Our privacy protocols comply with privacy legislation and standards of our regulatory bodies and the law

Do not hesitate to discuss our policies with your registered massage therapist or any members of this office staff.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and/or the Massage Therapy Act (MTA) and for the defense of legal issue.

I will not supply your insurer with your confidential medical history. In the event this kind of request is made, I will forward the information directly to you for review, and for specific consent. If any unusual requests for information are received; we will contact you for permission to release such information. I may also advise you if such a release is inappropriate.

By signing the consent section of this form, you have agreed that you have given your informed consent to the Registered Massage Therapist at River Oaks Chiropractic and Wellness Centre for the collection, use and/or disclosure of your personal information. If a new purpose arises for the use and/or disclosure of your personal information, I will seek your consent in advance.

You may withdraw your consent for use and/or disclosure of your personal information at anytime.

Patient Consent

I know that this clinic has a Privacy Code, and I can ask to see the code at anytime.

I agree that the Registered Massage Therapist can collect and disclose my personal information as set out above.

Print Name

Signature

Date

Witness

Complimentary Subscription to Healthy Living Newsletter

Please indicate which topics are of interest to you. Newsletters containing information on your topics of interest will be sent to you by email.

Check off topics of interest:

- | | | |
|---|---|--|
| <input type="checkbox"/> Backaches & Sciatica | <input type="checkbox"/> Headaches & Neck Pain | <input type="checkbox"/> Wellness Topics |
| <input type="checkbox"/> Diet & Nutrition | <input type="checkbox"/> Exercise & Fitness | <input type="checkbox"/> Women's Health Issues |
| <input type="checkbox"/> Children's Health | <input type="checkbox"/> Issues Stress Management | <input type="checkbox"/> Doctor's Announcements
& upcoming events/talks |

Name: _____ E-Mail Address: _____

- I do not give consent to have my first name added to the Thank you/welcome board in the clinic reception area.