PATIENT DECLARATION AND 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 (CMTO).

I hereby consent for my therapist to treat me with massage therapy for the purposes that I have indicated to her on the Health History Intake Form in writing and/or have discussed in confidence with her, 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 clearly understand that 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 of guarantee has been provided to me regarding 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 the medical health history intake form provided by the therapist and disclosed to the 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 my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my con sent to treatment and intend this consent to cover the treatment discussed with me as such additional treatment is proposed by my therapist to deal with my medical condition for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I understand the 24 hour cancellation policy in effect and that I must provide at least 24 hours' notice of cancellation of an appointment. I understand that my account can be charged the full fee for all missed appointments or appointments cancelled within 24 hours of the appointment time, at the discretion of the therapist.

I, ____ (NAME OF PATIENT PRINTED)

ACKNOWLEDGE and DECLARE that I am aware and agree to all the above and I thereby authorize examination and treatment by:

REGISTERED MASSAGE THERAPIST: ___CHARLOTTE SCOTT, RMT____________________

DATE: ____ (Month, Day, Year)

PATIENT SIGNATURE: ____

Parent/Guardian Signature (if a minor): ____

Print Name: ____