Consent for Massage

In according with the standards of Practice and the Code of Ethics of the College of Massage Therapists in Ontario:

- I had the opportunity to discuss the nature and the purpose of the proposed assessment/reassessment/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 hours notices will be subject to full payment of the scheduled appointment.

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, then client, fully understands 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 issue that I may present with. I understand that I may alter or withdraw my consent at any time.

***For insurance company purposes** – I am giving my consent to the Therapist/Clinic by signing below to share information related to my treatment such as but not limited to: Name, Date and Time of the treatment, amount that was paid, if such was requested by my insurance company.

Patient Name __________________________.

Signature of the patient (or Decision maker)___________________________________.

Date Signed ___________________________.