Informed Consent – MASSAGE THERAPY

I hereby request and consent to the service of massage therapy treatment and other massage procedures, including various modes of remedial exercise and hydrotherapy, on me by the registered massage therapist.

I understand that I will have an opportunity to discuss with the massage therapists and/or with other office or clinic personnel, the nature of massage therapy treatment and other procedures. I understand the results may not be guaranteed.

I am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, bruising, light headed or dizziness, and tenderness. I do not expect the massage therapist to be able to anticipate and explain all risks and complications and I wish to rely on the massage therapist to exercise judgment during the course of the treatment which the massage therapist feels at the time, based upon the facts then known, and is in my best interests.

I understand that I will be draped at all times and the areas undraped will be secure to insure there is no indecent exposure. If undraping my gluteals is significant in the treatment I do understand that it is part of the therapy.

I am informed that I have the right to terminate the treatment at any time, and the right to alter the therapist's pressure during the massage treatment.

I am aware there are further alternatives offered such as chiropractic, acupuncture, reflexology, and physiotherapy etc.

I have read the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of the treatment for my present condition and for any future condition(s) for which I seek treatment.

Cancellation and No Shop Policy

The Campus Health Care Centre has a 60 minute cancellation and no show policy. Patients must notify the reception more than 60 minutes prior to an appointment. Failure to do so will result in a $40 cancellation and no show fee.

Dated this _____ day of _____, 20_____.

Patient Signature (Legal Guardian)	Witness of Signature
Name:	Name:
(please print)	(please print)