Tricia Wannamaker RMT
250 Bridge Street West
Belleville, Ontario K8P 5N3
Ph: 613.771.0055

info@foryourrelief.ca

INFORMED CONSENT FOR MASSAGE THERAPY TREATMENTS

I hearby request and consent to the service of a massage therapy treatment and other massage procedures, including various modes of remedial exercise and hydrotherapy, on me by the Registered Massage Therapist Tricia Wannamaker RMT.

I have had an opportunity to discuss with the massage therapist and/or with other office or clinic personnel, the nature of a massage therapy treatment and other procedures. I understand that results are not guaranteed.

I further understand and 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 judgement 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 ensure there is no indecent exposure. If undraping of my gluteus is significant in the treatment, I do understand that it is part of the therapy.

I further understand that there are alternatives such as, Chiropractic adjustments, acupuncture, physiotherapy, occupational therapy and athletic therapy, etc.

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

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 treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT:

PRINT PATIENT'S NAME____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN ____

DATE SIGNED ____

WITNESS TO SIGNATURE ABOVE____

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Fee Schedule

90 MINUTE MASSAGE TREATMENT	$140.00
ONE HOUR MASSAGE TREATMENT	$100.00
FORTY-FIVE MINUTE MASSAGE TREATMENT	$80.00
HALF-HOUR MASSAGE TREATMENT	$70.00

*******************FEES ARE PAYABLE AT THE TIME OF TREATMENT*******************

PAYMENT METHODS: DEBIT, CREDIT CARD, E-TRANSFER, CASH OR CHEQUE

CANCELLATION POLICY:

Collaborative Care will require **24 hours'** notice for cancellation of appointments. If notice is not given, **100%** of the scheduled appointment fee may be charged.

Please see Tricia if you have any questions.

I understand and agree that health and accident policies are an arrangement between and Insurance Company and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment.

PATIENT'S NAME ____

PATIENT, GUARDIAN OR SPOUSES SIGNATURE ____

DATE ____