Registered Massage Therapy

Confidentiality Agreement and Informed Consent to Treatment

Registered Massage Therapists are health care professionals committed to restoring and maintaining optimal health and pain-free function of the body. They are educated and trained to accurately assess and treat with techniques that include massage and manual therapy, joint mobilization, hydrotherapy, and rehabilitative exercise such as stretching, strengthening, postural exercise and patient education. Prior to receiving treatment, patient should understand the following:

Risks, Complications & Side Effects: My initials indicate that I acknowledge and understand that:

___ There are risks associated with Massage Therapy. Examples include: bruising, aching, discomfort, short term aggravation of symptoms, and skin irritation.

___ My RMT has discussed with me the nature and purpose of the proposed treatments, the possible alternative methods of treatment, the risks involved and the possible complications and side effects.

___ I have discussed my concerns about possible risks with my therapist BEFORE signing this document. If I develop a concern after signing, I agree to discuss the same with the RMT immediately.

Disclosure of Medical History: My initials indicate that I acknowledge and understand that:

___ It is important for the RMT to know my relevant medical history.

___ I have disclosed to the RMT all medical conditions, including any mental or emotional conditions for which I have received treatment within the last 12 months.

___ I will disclose any new such condition that may develop after my completion of this form.

___ The information disclosed by me is true and complete to the best of my knowledge.

___ **Sharing of My Patient Record:** My initials confirm that I request and authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future or request a copy by paying the appropriate fee.

Confidentiality: The contents of this form and my patient records will be kept confidential unless I have expressed or written consent to the release of my information or where there is a legal requirement to provide my information to a third party.

No Guarantee of Results: I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding my treatments. I do not expect the Massage Therapist will be able to anticipate and explain all risks and complications.

Changes to Treatment Plan: I acknowledge and confirm that it may be necessary for the RMT to adjust their treatment plan during my treatment, in which case they will discuss that with me.

Areas of Treatment:

Back Arms Neck/Shoulders Legs Other: _____

DO <u>NOT</u> SIGN THIS FORM UNTIL YOU MEET WITH THE REGISTERED MASSAGE THERAPIST

• Ask questions about your treatment at ANYTIME.

• Immediately advise your RMT if you become uncomfortable in any way with your treatment.

With this knowledge, I voluntarily consent to the therapeutic procedures mentioned above and I intend for this consent form to cover the entire course of treatment with this Massage Therapist, until changes to the treatment plan are made, and consent is re-established.

Patient Name: (Please Print)_____

Name of guardian if patient is a child: _____

Signature of Patient (Of Guardian): _____

Date (mm/dd/yyyy): _____/_____/_____

Is this your first Massage? • Yes • No Date of last Massage:_____

Practitioner Name: _____

Practitioner Signature: _____