INFORMED CONSENT

This letter is to inform you of your rights as a patient. In Ontario, massage therapy is regulated under the regulated Health Professionals Act. This act empowers patients such as yourself, with regards to their health care treatments. What this means is that you have the right to make decisions regarding your health care. If you are uncomfortable or unsatisfied with your treatment plan you have the right to alter or terminate it at anytime. If you have any questions regarding your treatment or your health, please feel free to ask.

Please inform your therapist of any major health concerns that are not listed on the case history form. By doing so, your therapist is able to design an appropriate treatment plan and provide you with the best possible care.

During your massage a variety of therapeutic techniques may be used. If you are uncomfortable with any of these techniques, please let your therapist know. Some people may experience mild side effects from their first massage. The side effects should subside as you continue the course of your treatment plan. These side effects may include mild tissue tenderness, headaches or fatigue.   A minority of people experience side effects while most people feel relaxed and rejuvenated.

Your personal health information will be treated with respect, sensitivity and privacy. Any information regarding your health history or massage treatments will not be disclosed to another party without your written consent. We are committed to protecting your privacy.

In consideration of other clients, we require an eight (8) hour advanced cancellation of massage treatments. There will be a full service charge for non-cancelled appointments.

I hereby consent to the massage therapy treatments as described by my therapist. I understand the desired effects and possible side effects of my treatment.   I recognize that my therapist and I are partners in my Health Care Program and I agree to take responsibility for my health care and lifestyle choices.

Signature: _____ Dated: _____