INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Saskatchewan, Inc.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my health history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I HAVE READ, UNDERSTOOD, and AGREE to the above consent.

SIGNATURE: _____ **DATE:** _____

MISSED APPOINTMENT / CANCELLATION POLICY

Your appointment time is reserved especially for you. If you are unable to keep your allotted time, we kindly ask that you give us a minimum of **24 hour advance notice** in order for us to give our therapists a reasonable amount of time to fill the appointment slot.

Because our therapists get affected directly when appointments are missed, or when appointments are cancelled with less than 24 hour notice, we will charge the full price of the time booked. This amount must be paid prior to your next scheduled appointment.

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of treatment actually given, **you will be responsible for the full session**.

Please understand that appointment reminders are a courtesy. In the event that we were unable to contact you, you are still responsible for showing up at your allotted treatment time. Our therapists also gratefully respect you and your time. We understand that all our patients have busy lives and, as such, our therapists will make sure that all appointments begin and end on time.

I HAVE READ, UNDERSTOOD, and AGREE to the above policy.

SIGNATURE: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____