Informed Consent – Massage Therapy

1. I hereby request and consent to the service of massage therapy and other massage procedures, including various forms of massage therapy, hydrotherapy, range of motion, stretches and orthopedic testing on me by the Registered Massage Therapist.

2. I understand that I will have an opportunity to discuss with the massage therapist and/or with other office or clinic personnel, the nature of massage therapy treatment and other procedures.

3. I understand the results may not be guaranteed.

4. I understand 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.

5. I understand, as in all health care, in the practice of massage therapy there can be risks to treatment, including but not limited to, tenderness, bruising, light headedness or dizziness. 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.

6. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical 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.

7. 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 undrapping my gluteals/hip rotators is significant in the treatment I do understand that it is part of the therapy. I will also have the privacy to undress/dressed and the therapist will knock and wait for my reply upon entering.

8. I understand that if I have or in future begin any sensitivities to lotions, oils I will notify my therapist.

9. **I understand that I have the right to terminate the treatment at any time, and the right to alter the therapist's pressure or techniques during the massage treatment.**

10. I am aware there are further alternatives offered such as Chiropractic, Acupuncture, Reflexology and Physiotherapy, etc.

11. I have read the above noted consent and I have had the opportunity to question the contents and my therapy. I understand that all treatments and information collected is held in confidentiality. By signing this form, I confirm my consent to treatment 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.

Please Print Name: _____

Signature: _____

Date: _____

Explanation of Massage Therapy Fees

Undressing and dressing are included in massage length along with any paperwork such as, updating of health history, assessments, etc., related to treatment.

Massage Length	Fee
30 minute	$52
45 minute	$68
60 minute	$85
90 minute	$130

Forms of Payment:

Patients are responsible for full payment at the time services are rendered. We accept Interac, Visa, MasterCard, personal cheque and cash.

Missed/Cancellation Appointment Policy:

Our office requires a 24 hour notice for cancellation of Massage Therapy Appointments. **Appointments missed or cancelled without sufficient notice will be charged $35.**

I consent to pay the above missed/cancellation fee at my next appointment.

Direct Billing Authorization:

Account#_____

Primary Account Holder name _____

Please be advised that I authorize my massage therapist at Lifetime Wellness Center to bill my health insurance company, provided above for direct billing payment. I acknowledge that the payment will be made directly to my massage therapist.

I have read, understood, and agreed to the fees and payment obligations as listed above.

Patient's Signature _____

Date signed _____

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone # _____

Address:_____

Occupation:_____ Date of Birth: _____

Have you received massage therapy before? Yes No

Did a health care practitioner refer you for massage therapy? Yes No

If yes, please provide their name and address. _____

_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular high blood pressure low blood pressure
chronic congestive heart failure
heart attack
phlebitis / varicose veins
stroke/CVA
pacemaker or similar device heart disease

is there a family history of any of the above? Yes No

Respiratory chronic cough shortness of breath bronchitis
asthma
emphysema

is there a family history of any of the above? Yes No

Infections
hepatitis skin conditions
TB
HIV
herpes

Other Conditions loss of sensation, where?
_____ diabetes, onset: _____
allergies/hypersensitivity to what?
_____
type of reaction: _____
epilepsy cancer, where?
_____
skin conditions, what?
_____
arthritis
is there a family history of arthritis? Yes No

Head/Neck
history of headaches
history of migraines
vision problems vision loss ear problems
hearing loss

Women pregnant, due:_____
gynaecological conditions, what?_____

Overall, how is your general health?
_____

Primary Care Physician:
_____
Address:
_____
_____

Current Medications:
_____ condition it treats: _____
_____

Are you currently receiving treatment from another health care professional? Yes No
If yes, for what? _____
_____

Surgery – date _____ nature:
_____

Injury – date _____
nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) Yes No
what? _____

Do you have any internal pins, wires, artificial joints or special equipment ? Yes No

what? _____
where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.

_____
_____
_____

Notes:

Date of Initial Health History: _____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____

Name: _____ Date: _____

Please locate discomfort & pain with an X