GSH

East Liberty Medical Centre

901 King Street West, Suite 105
Toronto, ON M5V 3H5

T (416) 599-6000
F (416) 599-9731

www.libertymd.ca

INFORMED CONSENT TO MASSAGE THERAPY ASSESSMENT AND TREATMENT

I have received information about the proposed physical assessment and have been informed about the nature of the massage therapy treatment. I have been informed and understand the benefits, risks, side effects, contraindications (if present), alternative courses of treatment and consequences of not having the treatment. I understand that it is my right to stop or modify the treatment at any time and that the massage therapist expects my input regarding the comfort of pressure throughout the treatment. The therapist has given me instruction on dressing/undressing procedures as well as instruction on positioning and covering during treatment, hydrotherapy applications and remedial exercises program. I am fully aware of the cost of treatment and duration of both the treatment and assessment.

Treatment	**Fee**
30 minutes	$55.00 + TAX
45 minutes	$70.00+ TAX
60 minutes	$85.00+ TAX
90 minutes	$135.00+ TAX

All information in my file will be kept confidential, although the file will be shared among the treating therapists in this facility. The sharing of the file will improve the flow of information among the professionals to ensure the utmost quality care.

I understand that written authorization will be obtained prior to any release of information, except when required by a court of law.

I understand that my treatment may change from time to time, and the necessary functional abilities test may be performed at my health professional's discretion. I also understand that results are not guaranteed.

I have read the above consent. I have also had the opportunity to ask questions about its consent. By signing below I agree to the proposed physical testing and massage therapy protocol presented by the registered massage therapist. I intend to consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

_____ _____

Patient Name Patient Signature

_____ _____

RMT Name RMT Signature

CANCELLATION POLICY

We require 24 hours notice for appointment cancellations. Should you fail to cancel or reschedule your appointment with 24 hours notice, you will be charged the full treatment fee. We ask that you leave your credit card number on file for the processing of such payment. The information will be held in strict confidence, as outlined in the consent form above. An invoice will be mailed to you when payments are processed.

Name of Card Holder:_____

Credit Card Number:_____

Expiry Date:_____ Please circle: Visa Mastercard

I give permission to East Liberty Medical Centre to charge the credit card listed above for any outstanding balance on my account.

Signature: _____

HEALTH HISTORY

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 requires by law. Your written permission will be required to release any information.

Name: _____ Phone:_____

Address: _____ Email:_____

_____

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 Asthma Shortness of breath Bronchitis 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:_____ Diabetes, onset:_____ Allergies/hypersensitivity: _____ Epilepsy Cancer:_____ Skin conditions:_____ Arthritis:_____ Is there a family history of any of the above? YES NO	**Head/Neck**: History of headaches History of migraines Vision problems Vision loss Ear problems Hearing loss **Women**: Pregnant, due:_____ Gynecological conditions: _____ _____ Overall, how is your general health? _____ Primary care physician: _____ Address: _____ _____

Current medications:_____
_____

Condition it treats:_____
_____

Are you currently receiving treatment from another healthcare professional? YES NO

If yes, for what? _____

Surgery

Date:_____

Nature: _____

Injury

Date: _____

Nature: _____

Do you have any other medical condition (digestive conditions, haemophilia, osteoporosis, mental illness)? YES NO

Do you have any internal pins, wires, artificial joints or special equipment? YES NO

If yes, please explain:
_____

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