Lifeforce Proactive
HEALTH CENTRE

INFORMED CONSENT TO MASSAGE CARE:

I hereby request and consent to the performance of massage therapy by any of the registered massage therapists working in the clinic, Heather Groot, Marianne Cottingham, Alanna Augustin, Leah Firth, McLelland Stewart and Erin McKay. I have had an opportunity to discuss with my therapist and/or other office or clinic personnel, the nature and purpose of my treatment. I understand the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment, including but not limited to, muscle soreness, possible bruising, joint sprains and strokes. I do not expect the RMT to be able to anticipate and explain all risks and complications and I wish to rely on the therapist to exercise judgement during the course of the treatment which the RMT feels at the time, based upon the facts then known is in my best interests.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

Please further note that your medical information and files belong to this clinic, Lifeforce Proactive Health Centre. Should you need to access them please contact the clinic.

If you would like to **decline** our monthly newsletter with office updates and valuable health tips please tick this box ☐

Patient's Name _____ Signature of Client or Guardian_____

Date _____ Witnessed _____