Health Consent Form

The Center of Impact Registered Massage Therapy

201 King Street West, Oshawa Ontario L1J 2J5

Tel. 905-240-5553, Fax. 905-240-5554

I am aware that my treatment will be explained fully to me and my informed consent will be required prior to treatment.

I understand that massage therapy may cause some discomfort, however the therapist will monitor my comfort level throughout the treatment. I understand that I may alter or end the treatment at any time without explanation.

I am aware of the cost of the treatment and agree that this fee must be paid at the end of each session. **Any missed or cancelled appointment without 24 hours' notice will be subject to a 50% missed appointment fee.**

The information that I have provided on my Health History form is current and accurate. If changes in my health status occur, I understand I am required to inform the massage therapist prior to the next treatment. I understand that the information in my file is confidential and will only be used for the purpose of my health care program.

I _____ do hereby authorize my Registered Massage Therapist to release or discuss all pertinent medical information regarding my diagnosis, treatment and prognosis to my insurance company, physician, physiotherapist, chiropractor or any persons working on behalf of the above. I hereby provide my consent for the assessment and treatment of my condition by a Registered Massage Therapist.

Signed on this _____ day of _____, 20___.

_____ _____

Print Name Signature