Movement Chiropractic
7-3602 Taylor Street East
Saskatoon, SK S7H 5H9

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. and/or the Natural Health Practitioners of Canada.

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

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 questions the contents of 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.

_____ **X**_____
PATIENT NAME (Printed) PATIENT (or Guardian) SIGNATURE

_____ _____
WITNESS DATE

MASSAGE THERAPY POLICY

To all massage therapy clients:

We would like to take this opportunity to inform you of the massage therapy policies of our clinic.

1. Six hours notice will be needed if you wish to cancel or change your appointment. This is required in order for us to be able to fill the space with another client who needs treatment.

2. If no notice or late notice is given you will be subject to the following charges:
   Half hour appointment - $20.00
   One hour appointment - $35.00

3. If you are late for your treatment, time will be deducted from your allotted treatment and you will be charged the regular fee according to the treatment booked.

If you require notification a day early for your treatment, please notify us so we may provide this service.

I, the undersigned, verify that I have read the policies set forth by Movement Chiropractic.

_____ _____

Patient Signature Date

* If you require a copy to take home, please let us know and a copy can be provided for you.

Thank You