New Leaf Kinetic Arts

INFORMED CONSENT TO MASSAGE THERAPY

Please initial beside each:

___ I acknowledge that my Therapist is not a physician and does not diagnose illness or disease or any other physical, mental or emotional disorders. I clearly understand that Massage Therapy is not a substitute for a medical examination. It is recommended that I consult my 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 these risks.

___ I understand that the Registered Massage Therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapy Association of Saskatchewan (MTAS), Inc., and the Natural Health Practitioners of Canada (NHPC).

___ I hereby consent to my Therapist to treat me with massage therapy for the above noted purpose, which may include assessments, examinations and resulting clinical impressions, in addition to techniques and homecare advice, which may be recommended by my Therapist.

___ I acknowledge and understand that my Therapist must be fully aware of any existing medical conditions. I have completed my **Patient Health History** form as provided by my Therapist and disclosed all of those medical conditions affecting me.

___ It is my responsibility to keep my Therapist updated on my medical history at all times. The information I have provided is accurate and complete to the best of my knowledge.

___ I authorize my Therapist to release or obtain information pertaining to my health, such as condition(s) and/or treatment(s), to/from other caregivers or third party payers.

___ I intend my confirmation to intend to cover the treatment discussed and such additional treatment as proposed by my Therapist from time to time, to deal with any condition and for which I have sought treatment.

___ I understand that I may withdraw my consent at any time and my treatment will be stopped.

___ I have read the above noted consent and have had the opportunity to question the contents.

By signing this form, I confirm my consent to treatment:

Date Signed: ____

Patient's Name (Please Print): ______________________________

Signature of Patient / Guardian*: ____________________________

*Signature of a Guardian is required for Patients under the age of 18