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| **Consent Form***Please read the following, and sign your consent below. Without patient consent, Massage Therapy treatments will not be performed.***“The practice of massage therapy is the assessment of the soft tissue and joints of the body and the treatment and prevention of physical dysfunction and pain of the soft tissues and joints by manipulation to develop, maintain, rehabilitate or augment physical function, or relieve pain.” 1991, c. 27, s. 3.**1. Massage Therapy is provided only when your RMT expects treatments will be beneficial to your condition.
2. The purpose of massage therapy is to decrease and/or prevent pain, and discomfort in soft tissue and joints.
3. Risks for receiving Massage Therapy are determined after your RMT reviews your health history form; any risks/side effects will be discussed with you.
4. Common side effects of Massage Therapy include: dizziness/light headedness while getting off the table after your massage, and local tenderness in the areas treated (local tenderness may last a few days).
5. Painful techniques will be discussed with you prior to each treatment.
6. Alternatives to Massage Therapy may include stretches or exercises, heat or cold therapy, and/or other suggestions by your RMT.
7. During Massage Therapy treatments, your RMT will only uncover the area that is being treated. At no point in time will you be inappropriately exposed by your RMT.
8. Clothing may be kept on, or removed for the massage at your comfort.
9. You have the right at any time during the massage to STOP, or modify the treatment being performed.

***I agree, that I understand all of the above, and that I have been given the chance to ask any questions related to the treatment proposed by my RMT.******I agree, that the owner of Veitch Chiropractic may have access to my name on file.*** ***Cancellation Policy****:* 24-hour notice for all appointment cancellations. For missed appointments, or cancellations less then 24-hours in advance, you may be required to cover the full cost of your appointment. **I give my full consent to receive Massage Therapy treatment.** Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |