Informed Consent

I certify that the information provided in my Medical History is, to my knowledge, exact. I recognize and admit my responsibility for all information not declared regarding my health past and present. I consent to communicating with my physician, if required, since my medical information may be necessary for my care. I have had the opportunity to ask questions regarding my Medical History and I understand that the "Helping Hands Massage Therapy" is under strict legal obligation to respect the confidentiality of my personal information.

I, the undersigned, hereby consent that my Therapist can treat me with massage therapy including such assessments, examinations and techniques, which may be recommended by my Therapist. I understand that the Massage Therapy services provided by the "Helping Hands Massage Therapy" aim to facilitate relaxation, reduce pain caused by muscle tension, increase joint mobility, improve circulation as well as provide a positive experience.

The general benefits of massage, its contraindications or precautions and the care plan (treatment) have been explained to me in a clear fashion. I clearly understand that massage therapy is not a substitute for a medical examination or medications. It is recommended that I attend my family physician for any ailments that I may be experiencing. I acknowledge that the Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder nor prescribes medication. 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 have had the opportunity to ask questions and receive answers concerning my care plan.

I am aware of the fees and policies of Helping Hands Massage Therapy and I certify that I have made a clear and informed choice concerning my evaluation and the care plan chosen.

I have read this consent and I have had the opportunity to question the contents of my care plan. 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(s) 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 cease.

Consent for Personal Information

I acknowledge and understand that my Therapist must be fully aware of my existing medical conditions. I have completed my Medical History Form as provided by my Therapist and have disclosed to my Therapist all of the medical condition(s) 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 recognize and admit that it is my responsibility for any oversight to declare my state of health past and present.

I authorize my Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other professional health care providers. I consent that my Therapist can contact my family physician, if required, as the information may be necessary for my care.

Client Name (printed):_____ Client signature: _____

Parent/Guardian Name (printed):_____ Parent/Guardian signature:_____

Date Signed:_____