Thank you for choosing Physiomoves Physiotherapy Clinic for all your rehabilitation needs.
Please read through the following information and sign at the bottom.

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT and RELEASE OF INFORMATION

I, the undersigned, voluntarily consent to the registered massage therapist ("RMT") and Physiomoves (the "Clinic") providing massage therapy services (the "Treatment") to me, now and on an ongoing basis, with such Treatment to be within the scope of the RMT practice as defined by the College of Massage Therapist of British Columbia, including without limitation, such assessments, examinations and techniques, as recommended by the RMT. I consent to the RMT undraping areas of my body to the extent needed to provide Treatment while considering my comfort, security, and privacy as requested by me. I understand that at any time I may withdraw my consent to Treatment by informing the RMT with words to that effect, and then Treatment will be stopped.

I agree that Treatment is not a substitute for a medical examination and diagnosis by a medical physician. I agree that no assurance or guarantee has been provided to me by RMT or the Clinic as to any results of Treatment.

Possible Risks Associated With Treatment

I agree that my consent is given while informed of the fact that possible and likely risks to me exist during the course of Treatment, including, but not limited to, muscle strains and sprains, bruising, light headedness, dizziness and tenderness. I agree that the RMT is not able to explain unanticipated risks and complications and as such there may be other risks associated with Treatment in addition to those identified above.

Duty to Disclose Medical History

I agree that I have a duty to fully disclose to the RMT and Clinic all medical conditions affecting me, whether or not I believe any medical condition is applicable or relevant to my Treatment. I further agree that it is my responsibility to keep the RMT updated and informed of my medical condition. I declare that the information I have provided in the above Medical History Form is true, accurate and complete.

Please continue on other side..

Disclosure of Personal Information

I understand that it may be desirable from time to time for the RMT and Clinic to coordinate my health care with others, including but not limited to other Clinic staff, physicians, other health care providers, case managers, and insurance claim adjusters ("Other Providers"), which results in disclosing my personal information (as defined in the Personal Information Protection Act (the "Act"). I consent to the RMT and Clinic disclosing my personal information to Other Providers, when done in accordance with the Act. I consent to the shared access between the RMT and the Clinic staff to my personal information. I agree that I must expressly withdraw consent of the disclosure of my personal information by providing 2-business day notice of such withdrawal of consent in writing to the RMT and Clinic.

By signing below I agree that I have read and understood the above information and that I have had the opportunity to ask the RMT and Clinic any questions regarding the contents of my consent and my Treatment.

I understand I am fully responsible for payment of services received from PHYSIOMOVES PHYSIOTHERAPY CLINIC.

In the event a third party insurer (WCB/ICBC/other) denies a claim or refuses payment in full or in part, I understand I am responsible for and agree to pay the outstanding amount.

Cancellation Policy

We require notice of cancellation 24 hours before your appointment. Same day cancellations will result in a %50 fee (exceptional circumstances will be considered). Please note that our reminder emails are for courtesy only. It is your personal responsibility to keep track of your appointments.

I have read and understood the above information.

Please provide us with your email for future contact: _____

Signature: _____ **Parent/Guardian: _____ Date:_____**
(If under 18 years old)

Thank You!

Physiomoves Physiotherapy Clinic
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