Coquitlam Integrated Health

100 – 2976 Glen Drive, Coquitlam, BC V3B 0G5 | F. 604.941.5486 | T. 604.941.5483
www.coquitlamintegratedhealth.ca | email: infocih@telus.net

PATIENT CONSENT

Your Registered Massage Therapist (RMT) will make every effort to ensure that your treatment is safe and effective. At any time, before or during therapy you have the right to ask that the treatment, or portions of the treatment, be discontinued, or inquire about the purposes of any technique being used. If you have questions or concerns related to the treatment, we encourage you to communicate with your therapist so there is clarification or modification of the treatment.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my MD and other health care practitioners as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.

DO NOT SIGN THIS FORM BEFORE SPEAKING WITH YOUR RMT. My RMT discussed with me:

___ the nature and purpose of the proposed treatments and how they will address my goals.

___ the risks involved, including possible side effects, examples of which include: bruising, aching, discomfort, short term aggravation of symptoms, skin irritation and/or a burning sensation.

___ the areas of my body that will be touched during treatment and why.

___ my options for disrobing prior to the treatment.

___ I confirm my RMT has addressed my concerns with the treatment plan to my satisfaction.

___ I agree to alert my RMT immediately if I develop a concern at any time.

___I authorize and consent to the RMT performing the treatments described to me.

___ I agree to tell my RMT immediately if I withdraw my consent.

___ the medical history disclosed by me is true and complete to the best of my knowledge.

___ I acknowledge and confirm that no guarantee or assurance of results has been made to me.

Signature of Patient or Guardian: _____ Date: _____

Name of Guardian and Relationship: _____