INFORMED CONSENT TO TREATMENT

Welcome to Alliance Physio! To ensure that you receive the safest and most effective care and that you understand the treatment you will be receiving, please review the information provided below.

- I understand that the massage therapist must obtain personal information and informed consent prior to a massage therapy treatment
- I have reviewed the attached Privacy Regarding collection, use, and disclosure of my personal information and I understand that steps have been taken to ensure my privacy. I understand how the Privacy Policy applies to me and I have had the opportunity to ask for clarification.
- I agree that the RMT may collect, use and disclose my personal information for clinical purposes.

30 Mins	$60.00
45 Mins	$75.00
60 Mins	$95.00

I understand that if I do not provide 24 hrs notice or do not call and reschedule my appointment, I will be charged for the treatment as that time is allotted to me.

- By signing this document I acknowledge that I have read and understand the above statement and agree to treatment based on this document. I consent to massage therapy treatments provided by an RMT at Alliance Physio.

Client Name(Print) Client Signature Date

PERSONAL HEALTH INFORMATION ACT- PRIVACY POLICY

As a Registered Massage Therapist, I am responsible for collecting, utilizing, and disclosing your personal information with your written consent. *This information may only be used for the purpose for which it was collected.* For example, I may use your information to contact you regarding appointments and to provide you with information on other services. If I desire to use this information on other purposes, I must obtain your consent.

Personal health information is collected to assess your health needs, offer options for treatment, and to then provide such treatment. This information also provides a baseline of health information from which I may form a safe and effective treatment plan and may identify changes over time. I am also required to report any serious misconduct or incompetence of another practitioner.

The College of Massage Therapists of Ontario requires me to collect information and keep records. As part of their regulatory activities, they may review my records for completeness. In addition, Canada Customs and Revenue Agency, Information and Privacy Commissioner and the Human Rights Commission may examine my records. In the case of a third party coverage of Massage Therapy (i.e. WSIB, Private Insurance etc), your consent is implied and legislative authority is addressed to me to collect and disclose the required information to demonstrate the clients entitlement to funding.

Your health information is protected in a locked cabinet. I am required to maintain my client records for minimum of 10 years after the last contact with a client. This enables me to respond to any questions or concerns from the client or other agencies. Following the 10 year period, I may destroy the file in a secure manner.

With only a few exceptions, the client has the right to see what personal information I have collected regarding your history and care. You may also ask to have a mistake corrected- this applies to factual information or to professional opinions that I may have formed. In some instances, documentation to confirm changes may be required. If there is a discrepancy, then you may wish to include a statement in your file.

Anytime I need to forward information to a third party, I must obtain your written consent and do my utmost to ensure the information is delivered in a secure manner.

Should you have any questions or concerns, do not hesitate to discuss them with me. Any further information on the privacy act may be obtained at www.privcom.gc.ca.

Alliance Physio

An accurate health history is an important tool used to ensure that it is safe for you to receive a massage treatment and helps the therapist in determining a proper treatment plan. Should your health history status change in the future, please inform the massage therapist so your health history may be updated accordingly. All information gathered for treatment is confidential except as required or allowed by law and to facilitate assessment or treatment. You will be asked to provide written consent for release of any information.

Name:_____ Date:_____

Address: _____ City: _____ Postal Code_____

Home Phone:_____Cell Phone: _____ Occupation_____

Date of Birth: _____ Email: _____

Doctor:_____ Phone: _____May I contact?☐Yes ☐ No

Emergency Contact: _____ Phone: _____

Private Insurance information

_____ _____ _____ _____

Insurance Company Member Name Plan # ID#

_____

Have you had a massage before? ☐ Yes ☐ No For relaxation or other reason?_____

Current Medication (s):_____

_____

Previous major illness, surgeries: _____

_____

Accidents (please give dates): _____

_____

Other medical conditions (i.e. diabetes, hemophilia):_____

Family History (major illnesses etc.): _____

Please indicate all conditions you have experienced. Mark C for current and P for past

Joint/Soft Tissue Discomfort:
_ Arms
_ Upper Back
_ Mid back
_ Neck
_ Lower Back
_ Degenerative Discs
_ Feet
_ Hands
_ Hips
_ Jaw
_ Knees
_ Legs
_ Osteoarthritis
_ Rheumatoid Arthritis
_ Shoulders

Skin:
_ Rashes
_ Itching
_ Bruise Easily
_ Dryness
_ Boils
_ Other

Reproductive:
_ Pregnant
_ Painful Menstruation
_ Heavy Flow
_ Irregular Flow
_ Menopausal
_ Pre-Menopausal
_ Birth Control

General Symptoms:
_ Fainting
_ Dizziness
_ Loss of Sleep
_ Fatigue
_ Nervousness
_ Numbness
_ Tingling
_ Paralysis
_Headaches (tension)
_ Migraines

Cardiovascular:
_ High BP
_ Low BP
_Coronary Heart Disease
_ Heart Attack
_ Phlebitis
_ Stroke/ CVA
_ Pacemaker
_ Heart Murmur
_ Palpitations
_ Varicose Veins
_ Swelling in ankles
_ Poor Circulation
_ Sinus Infections

Respiratory:
_ Chronic Cough
_ Bronchitis
_ Asthma
_ Smoking
_ Emphysema
_ Pneumonia

Infectious:
_ Hepatitis
_ Tuberculosis
_ HIV
_ Herpes
_ Athlete's Foot
_ Warts
_ Other

Digestive
_ Poor appetite
_ Gas
_ Constipation
_ Diarrhea
_ Nausea
_ Ulcer
_ Vomiting

Eye, Ear, Nose, Throat
_ Allergies
_ Hearing Aids/ Loss

I attest that the information I have provided is true and complete to the best of my knowledge. I understand this information to be confidential and will not be released without my written consent. I consent to therapeutic massage treatment by any RMT at Alliance Physio.

Signature: _____ **Date:**_____