MONTGOMERY
CHIROPRACTIC
PLUS

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Alberta.

I hereby consent to my Massage Therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended by my Therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or and other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. 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 acknowledge and understand that the Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Therapist and disclosed to the Therapist all of those medical conditions 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 authorize my Therapist to release or obtain information pertaining to my conditions(s) and/or treatment to /from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the Contents. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatments as proposed by my therapist from time to time, to deal with my physical conditions and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____ _____

Patient Printed Name Signature of Patient / Guardian

_____ _____

Therapist Date Signed