PHYSIOTHERAPY
ADVANCED REHAB
Orthopaedic and Sports Injury Clinic
1250 Eglinton Ave. West, Unit A15 Mississauga, ON L5V 1N3
Tel: 905-997-7200 Fax 905-997-5000

Massage Therapy Consent Form

☐ I give my consent to receive massage therapy treatment at Physiotherapy Advanced Rehab.

☐ I understand that cancellation of appointments must be made 24 hours before the scheduled appointment and that failure to notify us within this time frame will result in a fee of 50% of the treatment costs.

☐ I fully understand and expressly agree that I will be personally responsible for the full cost of services rendered at *Physiotherapy Advanced Rehab* if my insurance company denies my claim and/or fails to cover the full costs.

☐ I fully understand and expressly agree that payment in full is required at the time of service if not billing a 3rd party insurer.

☐ I understand that treatment can be interrupted at times in order to facilitate communication for the massage therapist to obtain feedback from me.

☐ I understand that the time reserved for my massage includes time for interviewing, assessment, massage treatment. I am aware that it is not necessary to remove all clothing for treatment and only to the extent I feel comfortable. I agree to communicate with my therapist if at any time I feel my well being is compromised.

☐ I am aware that I may experience possible side effects from the treatment, such as temporary discomfort, bruising, headache, and/or dizziness.

☐ I understand that the information I provide is confidential and shall not be released without consent.

☐ I understand that the therapist and clinic are not responsible for any lost, stolen or damaged articles.

☐ **I understand** that the service fees may not be covered or exceed my plan or claim benefits and I am financially responsible for the entire cost of any unpaid claims

Physiotherapy Advanced Rehab (Health Information Custodian for your records) is responsible for protection, collection, use and disclosure of your personal information according to privacy rules set by Personal Health Information Protection Act (PHIPA) and by Personal Information Protection and Electronic Documents Act (PIPEDA)

I have read through and agreed to the above conditions.

_____	_____	_____
Patient/Guardian (please print)	Patient Signature	Date