INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

(Thai Tibetan Aroma Oil Massage)

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

I hereby consent to my Therapist to treat me with massage therapy for the above noted purposed including such assessments, examination 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 any 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. 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 have 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 condition(s) and/or treatment to/from my other caregivers or third party payers (eg: WCB / SGI / Medical Doctor or Chiropractor)

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

_____ _____

Patient Name (printed) Signature of Patient / Guardian

_____ _____

Date Signed Witness (signature)