Confidentiality Agreement and Informed Consent to Treatment
For Massage Therapy Patients

Registered Massage Therapists are health care professionals committed to restoring and maintaining optimal heath and pain-free function of the body.

They are educated and trained to accurately assess and treat with techniques that include massage and manual therapy, joint mobilization, hydrotherapy, and rehabilitative exercise such as stretching, strengthening, postural exercise and patient education.

I understand that I must inform my massage therapist immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant or suspect I may be pregnant.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or unless law requires it. I understand that the massage therapists at this clinic are legally obliged to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that fees are payable at the time of appointment.

I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee.

I understand that the results are not guaranteed. I do not expect the Massage Therapist(s) will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the therapeutic procedures mentioned above. I intend this consent form to cover the entire course of treatment with any/all Warmland Registered Massage Therapist(s). I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (Please Print)	Signature of Patient (or Guardian)
Name of guardian if patient is a child	Today's Date

☐ Optional Consent (please initial box)

I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to in the future) at Warmland Massage Therapy Clinic for the sole purpose of improving my current heath condition and/or to discuss current and/or future treatment options.

Massage Therapist (Please Print)	Signature of Massage Therapist