Health MOMENTUM CENTRE FOR THERAPEUTIC MEDICINE

Declaration And Consent To Treatment

Even natural therapies have the potential to cause adverse reactions. To help reduce this possibility, it is very important that you inform your registered massage therapist (RMT) of any disease process that you are suffering from, if you are on any medication or over the counter drugs, if you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding.

Despite intensive training and precautionary measures, there is always the possibility of health risks from natural therapies. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Pain, bruising, injury, fainting or tissue damage from bodywork, including cranial work and visceral manipulation

I understand that the results are not guaranteed. I do not expect the RMT to be able to anticipate and explain all risks and complications. I will rely on the RMT to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. I intend this consent form to cover the entire course of all treatments and therapies prescribed. I understand that I am free to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures that are suggested to me from my RMT and are aware of the unlikely, however possible, risks involved.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

I. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may receive from another licensed health care provider.

II. I am at liberty and encouraged to seek or continue medical care from other Health Care providers, such as General Medical Practitioner's or Specialists.

III. The treatment and therapies rendered or recommended by Health Momentum may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive at Health Momentum and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, as well as other applicable fees.

Parents/Guardians

☐ **I AGREE that I am solely responsible for the safety of my child/children while on the premise of Health Momentum. Children are to be supervised at all times and never left un-attended by the parent.**

Cancellation Policy

☐ **I AGREE that if I am unable to make my appointment, I must provide advance notification within 2 business days. If I fail to meet this deadline a late fee will be applied.**

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Signature of Patient Date

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