**Veronica Prior, RMT, Registered Massage Therapist**

**POLICIES**

**Privacy Policy**

The information gathered from your health history is strictly confidential and is used only to help establish the best treatment plan for you. The release of information cannot be given without written consent.

**Payment**

At this time, only cash or cheque is accepted.  A receipt is provided so it can be submitted to your extended health benefits for reimbursement. Payment is due when treatment is rendered.

**A $35.00 fee will be charged for NSF Cheques**

**Extended Health Coverage**

Everyone's coverage is different, please check with your extended health benefits provider to know your coverage.

**Cancellation/Missed appointments/Late Arrival Policies**

Your time is scheduled for you. Missed appointments will result in full fee charge. Late arrival will effect your treatment length and you will still be billed for the time you have booked.  24 hours notice is required for cancellation.

In the event that you are ill, especially if it is transferrable, I do ask that you call and reschedule your appointment.

**Fee Schedule**

**30 Minute= $50.00**

**45 Minute= $65.00**

**60 Minute= $80.00**

**90 Minute= $115.00**

Fees include HST. Fees are subject to change, only with advance notice.

Most Extended Health Benefits do cover a portion of Massage Therapy. Please check with your extended health care provider for details on your coverage.  Receipts will be provided for your reimbursement as I do not do direct billing.

**Contact Information/Follow-Up Call Leave Message Yes No**

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below I have read and understand all the above information.

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Veronica Prior, RMT, Registered Massage Therapist**

**Informed Consent to Massage Therapy Treatment**

I understand that the Massage Therapy is providing massage therapy services within their scope of practice as defined by both the College of Massage Therapist of Ontario and the Massage Therapist Association of Ontario.

I hereby consent for my 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, 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 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 health 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 obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers, only when necessary and with signed consent.

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 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 anytime, I may withdraw my consent and treatment may be stopped.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness (Print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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