BAYSWATER
NEUROMUSCULAR & MASSAGE

CONSENT TO TREATMENT

PATIENT NAME: _____DOB (DD/MM/YYYY):____/____/_____

Please read this document, including **Schedule A**. Ask your RMT any questions you have regarding the contents of this form before you sign. You are encouraged to ask questions about your treatment at any time.

TO BE COMPLETED BY PATIENT

Disclosure of Medical History

- It is important for the RMT to know my relevant medical history.
- I have disclosed to the RMT all medical conditions, including any mental or emotional conditions for which I have received treatment within the last 12 months.
- The information disclosed by me is true and complete to the best of my knowledge.
- If my condition should change, I will notify my RMT before subsequent treatments.

_____My initials indicate that I understand.

TO BE COMPLETED BY PATIENT WITH RMT PRIOR TO TREATMENT

Treatment Plan

- My goals for my treatment;
- the therapeutic rationale for the proposed treatment;
- possible alternative methods of treatment;
- the anticipated benefits and possible negative effects of the treatment, examples of which include bruising, aching, discomfort, short term aggravation of symptoms, skin irritation and/or
- _____
  _____
- the areas of my body where treatment will be delivered

- my options for disrobing; and
- my options for draping during the treatment.

_____**Before signing this form**, my RMT discussed the above elements of the Treatment Plan with me.

Concerns Addressed

I confirm I have no concerns with the treatment plan; **or** I confirm that I have discussed my concerns about the Treatment Plan with my Therapist **before** signing this document. Those concerns were:

_____
_____
_____

Consent to Treatment:

- I consent to the RMT performing the treatments described to me in the Treatment Plan.
- I understand that I may withdraw my consent to this treatment at **any time**.
- I agree to tell my RMT if my goals of treatment change, as my RMT may need to amend the Treatment Plan.
- If I have concerns during treatment, I will advise my RMT **immediately**.

_____My initials indicate that I understand.

Confidentiality

The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

No Guarantee of Results

I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding my treatments.

Signature of Patient*:_____Date (dd/mm/yyyy) _____/_____/_____

(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: _____)

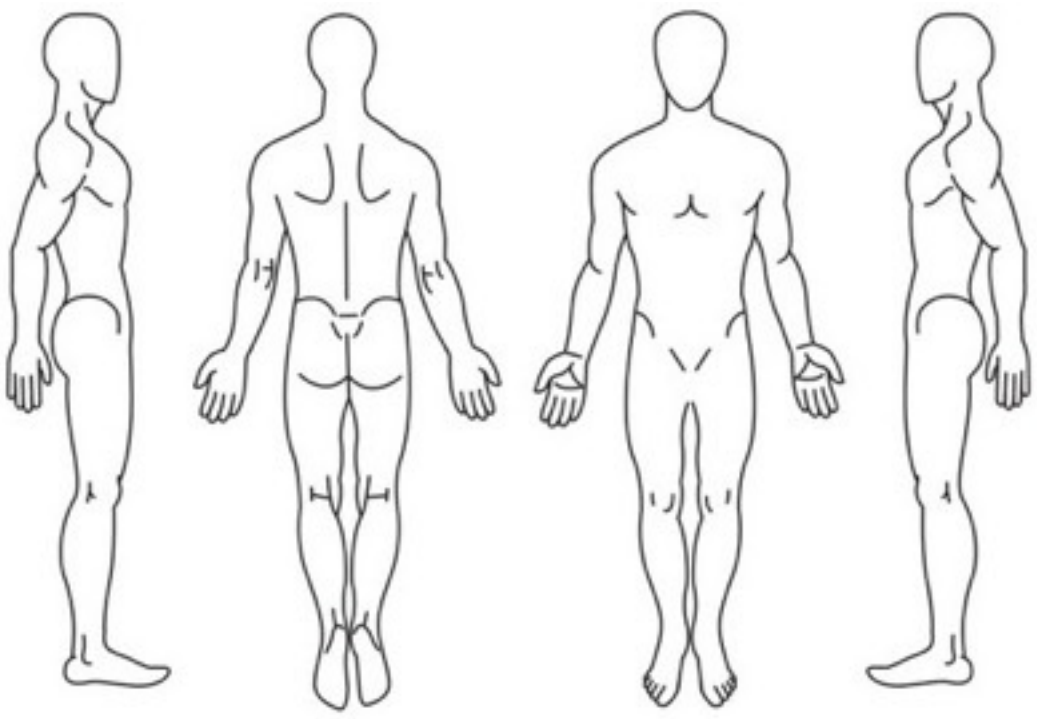
SCHEDULE A

Consent to Treatment of:

PATIENT NAME:_____**DATED (DD/MM/YYYY):**_____/_____/_____

Body Areas to be Treated

I acknowledge and confirm that this document forms part of the **Consent To Treatment** document previously signed by me and also applies to this treatment on this date.
I consent that the areas of my body circled on the diagram below may be touched by the RMT during my treatments:



It may be necessary for the RMT to adjust their treatment plan during my treatment, in which case they will discuss that with me.

Signature of Patient*: _____Date (dd/mm/yyyy) _____/_____/_____

(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: _____)

COVID-19 Patient Intake Consent

Yes_____ No_____	Do you have a fever, a new cough, a worsening chronic cough, shortness of breath or difficulty breathing?
Yes_____ No_____	Have you had close contact with anyone with acute respiratory illness or have you travelled outside of Canada in the past 14 days?
Yes_____ No_____	Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?
Yes_____ No_____	Do you have 2 or more of the following symptoms: Sore throat, runny nose/sneezing, nasal congestion, hoarse voice, difficulty swallowing, decrease or loss of sense of smell, chills, headaches, unexplained fatigue/malaise, diarrhea, abdominal pain, or nausea/vomiting?
Yes_____ No_____	If the person is over 65 years of age are they experiencing any of the following: delirium, falls, acute functional decline, or worsening of chronic conditions?

I understand that while the therapist is following all of the health and safety guidelines outlined by the Registered Massage Therapists Association of British Columbia, the College of Massage Therapists of British Columbia, and the Provincial Health Officer and that they are taking all reasonable precautions to clean and disinfect the clinic and all the surfaces within the treatment room, there are no guarantees that I may not come into contact with COVID-19.

Signed_____ Date: _____