ARC PHYSIO HEALTH

2520 Eglinton Avenue West, Unit 5-6 Mississauga, ON L5M 0Y4
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Massage Therapy Consent Form

☐ I give my consent to receive massage therapy treatment at Arc Physio Health.

☐ I fully understand and expressly agree that I will be personally responsible for the full cost of services rendered at Arc *Physio Health* if my insurance company denies my claim and/or fails to cover the full costs.

☐ I fully understand and expressly agree that payment in full is required at the time of service if not billing a 3rd party insurer.

☐ I understand that treatment can be interrupted at times in order to facilitate communication for the massage therapist to obtain feedback from me.

☐ I understand that the time reserved for my massage includes time for interviewing, assessment, massage treatment. I am aware that it is not necessary to remove all clothing for treatment and only to the extent I feel comfortable. I agree to communicate with my therapist if at any time I feel my well being is compromised.

☐ I am aware that I may experience possible side effects from the treatment, such as temporary discomfort, bruising, headache, and/or dizziness.

☐ I understand that the information I provide is confidential and shall not be released without consent.

☐ I understand that the therapist and clinic are not responsible for any lost, stolen or damaged articles.

☐ **I understand** that the service fees may not be covered or exceed my plan or claim benefits and I am financially responsible for the entire cost of any unpaid claims

☐ **Cancellation Policy:** Each appointment is booked and that time is reserved for you. We require 24 hour notice to cancel your appointment. Any missed or cancelled appointments without the required 24 hour notice will be charged a **$25 cancellation fee**. This fee is not covered by your extended health provider and you will be responsible for covering the cost. **Initial required** ____________

Arc Physio-Health (Health Information Custodian for your records) is responsible for protection, collection, use and disclosure of your personal information according to privacy rules set by Personal Health Information Protection Act (PHIPA) and by Personal Information Protection and Electronic Documents Act (PIPEDA)

I have read through and agreed to the above conditions.

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Patient/Guardian (please print)	Patient Signature	Date