# REGISTERED MASSAGE THERAPY

**Informed Consent for Payment and Treatment**

**Please Note:**
***24 hours notice of cancellation*** is required or you will be charged a no show fee of **$50.00**. Payment for all treatment is required at the time of the appointment. **Initial: _____**

I authorize the clinic and its associated RMT's to collect my personal and medical information in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers or at the email address I have provided. In addition, I authorize the clinic and its associated RMT's to communicate with my referring MD as deemed necessary for my beneficial treatment. I am aware that ASCI and its associated practitioners take great care to protect and preserve confidentiality regarding my personal and medical information; however, I also understand that this is a multi-disciplinary clinic and occasionally other practitioners may see my clinical chart notes as necessary for collaborative care. I understand that my personal and medical information is confidential and will only be disclosed to third parties with permission. **Initial: _____**

I am aware that the treatment begins with a period of dialogue regarding my health history with the RMT, then an assessment of soft tissue and joints in my affected areas, followed by the massage, when the RMT will use manual techniques including manipulation and mobilization to promote health, physical function, and pain relief.

I am also aware that some possible risks of massage therapy include, but are not limited to, an increase of pain, soreness, nausea, and fatigue and any of these may occur with treatment.

I understand that I can ask the RMT questions at anytime throughout the treatment.

_____ Date: _____

Signature of patient (or legal guardian)

*Label Placement*