The Loft - Registered Massage Therapy & Wellness

25 Milling Road
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Authorization of Consent

An accurate health information history is important to ensure that you receive a safe effective treatment.

Please read the following and sign.

I understand that all information gathered for this treatment remains confidential except as required or allowed by law or to facilitate assessment or treatment. I also understand that the therapist may discuss my case with peers who are under the same confidentiality clause in order to provide the best treatment possible. No other personal information will be disclosed other than that which is directly associated with my care / treatment.

I understand that my personal contact information is used for scheduling appointments, reminder calls, treatment follow-ups, mailing newsletters, greeting cards or thank you cards and for billing purposes. I also understand that I have the right to access the privacy policy for more details, which is available upon request.

I understand that if any third party requests my personal health information, I have the option to sign a consent of disclosure agreement before any information will be made available to them and only that to which I consent to will be made available except as required by law.

I understand that I have the right to withdraw my consent at any time, but am not able to withdraw that consent retro-actively.

I understand that my initial visit will include completion of case history form and any necessary questions, blood pressure reading and orthopedic assessments. Your health history form and blood pressure will be updated yearly.

I understand that a cancellation policy is in effect. If the need arises to cancel an appointment, please give 24 hours notice. If less than 24 hours notice is given a cancellation fee up to the value amount of the missed appointment may be administered at the discretion of the RMT.

I understand that I can request clarity on any of the following:

□Fee Schedule and Cancellation Policy	□Nature of Treatment	□Purpose of Assessment
□Home Care/Remedial Exercises	□Undress to Comfort Level	□Alternatives to Treatment
□Consequence of not Receiving Treatment	□Areas of the Body Involved	□Draping/Positioning/Pillows

I understand I have the right to request modifications or stop the treatment at any point. I can also refuse, alter or rescind consent at any time. I have read and understood all information set forth in this document and have had the opportunity to ask any questions regarding the treatment/treatment plan identified on this consent form.

I hereby authorize my consent for ____________________, RMT, to perform the proposed and future treatments.

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Client Signature Date

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RMT Date