Second Avenue Massage Therapy
724 2nd Avenue North
Saskatoon, SK
S7K 2E1

Please note: ***Your appointment time is reserved especially for you. A CANCELLATION FEE will be charged if a minimum of 3 hours notice is not received to cancel or reschedule an appointment. This will also affect SGI/WCB/DVA clients and the respective insurer will be notified of appointments not cancelled or missed. The cancellation fees are as follows:***

30 minute massage	**$35.00**
45 minute massage	**$45.00**
60 minute massage	**$57.75**
90 minute massage	**$70.00**

_____(initials)

Thank you for your co-operation and understanding!

_____

SIGNATURE

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapists' Association of Saskatchewan, Inc.

I hereby consent to 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 or 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 medical 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 or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above-noted consent and I have had the opportunity to question the contents of my therapy. By signing this form, I confirm my consent 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 any time, I may withdraw my consent and treatment will be stopped.

_____ _____

Patient Name (Please Print) **Signature of Patient/Guardian**

_____ _____

Witness **Date signed**