BIHC
Belleville Integrative Health Centre

777 Bell Boulevard W, Belleville, Ontario K8N4Z5

MASSAGE THERAPY

I hereby request the performance of massage therapy on me by a Registered Massage Therapist. I have had the opportunity to discuss with my therapist and/or other clinic personnel the nature or purpose of massage therapy. I understand that results are not guaranteed.

I understand and am informed that, as with all health care in the practice of massage therapy there are some risks to treatment, including but not limited to:

- sprains, strains, disc injuries, fractures, and bruising

I do not expect the massage therapist to be able to anticipate and explain all risks and complications. I wish to rely upon the practitioner to exercise judgement during the course of procedures, which the practitioner feels at the time, based on the facts then known, are in my best interests.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content. By signing below, I agree to the above-named procedure. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

It is very important that you inform your Massage Therapist immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your Massage Therapist immediately if you are pregnant, suspect that you are pregnant or if you are breastfeeding.

CONSENT FOR THE COST OF SERVICES

I understand that I am responsible to pay the fees for massage therapy that I receive at each session. Fees are due at the end of each appointment once services are rendered.

The fees for each treatment are:

30 Minute session	$55.00 + HST
45 Minute session	$70.00 +HST
60 Minute session	$90.00 +HST
90 Minute session	$130.00 +HST
120 Minute session	$170.00 +HST

Initial appointment must be 60 minutes unless otherwise stated by a health professional.

_____	_____	_____
Date Signed	**Print Patient Name**	**Signature of Patient (or parent/guardian)**
_____	_____	_____
Date Signed	**Print Witness Name**	**Signature of Witness**