## CONSENT TO TREATMENT & RECORD SHARING

## [INSERT NAME OF CLINIC] ("Clinic")

**Patient Name:**_____ DOB: (dd/mm/yyyy): ___/___/_____

- **Please read this document, including Schedule "A", carefully and completely.**
- DO NOT SIGN THIS DOCUMENT before speaking with your RMT.
- Ask your RMT any questions you have about this form or its contents BEFORE you sign.
- Ask questions about your treatment at ANYTIME.
- IMMEDIATELY advise your RMT if you become uncomfortable in any way with your treatment.

| **Treatment Plan:** |
|---|
| __ BEFORE SIGNING THIS FORM, my RMT discussed the following elements of the Treatment Plan with me: |
| • My goals for my treatment; |
| • the nature and purpose of the proposed treatments and how they will address my goals; |
| • the possible alternative methods of treatment; |
| • the risks involved, including the possible complications and side effects, examples of which include: bruising, aching, discomfort, short term aggravation of symptoms, skin irritation and/or _____ ; |
| • the areas of my body that will be touched during treatment and why; |
| • my options for disrobing prior to the treatment; and |
| • my options for draping during the treatment. |
| __ I confirm that I agree with the proposed Treatment Plan. |

| **Concerns Addressed:** |
|---|
| __ I confirm I have no concerns with the treatment plan; OR I confirm that I have discussed my concerns about the Treatment Plan with my Therapist BEFORE signing this document. Those concerns were: _____ |
| __ I confirm my RMT has addressed my concerns to my satisfaction before the treatment has begun. |
| __ I agree to alert my RMT immediately if I develop a concern at any time. |

| **Consent to Treatment**: |
|---|
| __ I authorize and consent to the RMT performing the treatments described to me in the Treatment Plan. |
| __ I acknowledge that I may withdraw my consent to this treatment at any time. |
| __ I agree to tell my RMT if my goals of treatment change, as they may need to amend the Treatment Plan. |
| __ I agree to tell my RMT immediately if I withdraw my consent. |

**Disclosure of Medical History:** My initials indicate that I acknowledge and understand that:

__ It is important for the RMT to know my relevant medical history.

__ I have disclosed to the RMT all medical conditions, including any mental or emotional conditions for which I have received treatment within the last 12 months.

__ I will disclose any new such condition that may develop after my completion of this form.

__ The information disclosed by me is true and complete to the best of my knowledge.

__ **Sharing of My Patient Record:** My initials confirm that I request and authorize my RMT to provide to the Clinic and to other health care practitioners who provide me with treatment, copies of any patient record created by my RMT. I understand this will enable the Clinic to maintain a complete patient record on my behalf. I understand that I may revoke this permission in writing at any time in the future.

**Confidentiality**: The contents of this form and my patient records will be kept confidential unless I have expressly or impliedly consented to the release of my information or where there is a legal requirement to provide my information to a third party.

**No Guarantee of Results**:

__ I acknowledge and confirm that no guarantee or assurance of results has been made to me regarding my treatments.

Signature of Patient*: _____ Date: (dd/mm/yyyy): __/__/____

(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: _____.)

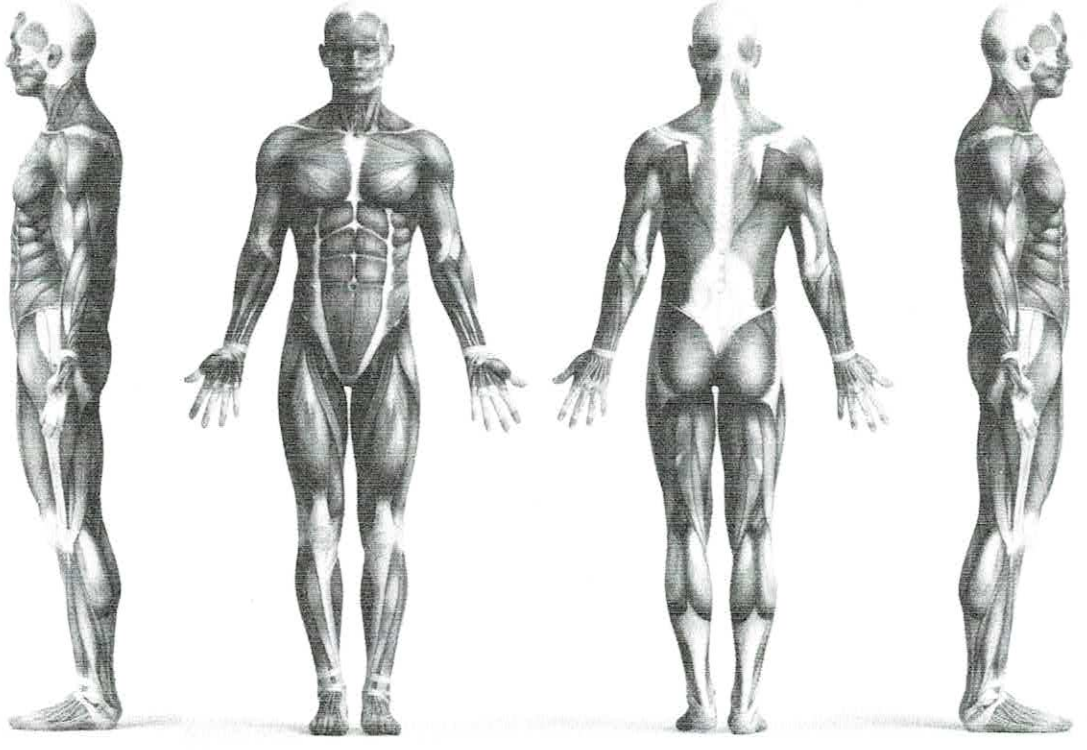
**Schedule A**
**to Consent to Treatment of**

(patient name) _____

dated (dd/mm/yyyy) __/__/_____.

**Body Areas to be Treated:**

I acknowledge and confirm that this document forms part of the CONSENT TO TREATMENT AND RECORD SHARING document signed by me and that my consent to treatment provided in that document applies to this treatment provided to me on this date above. I also acknowledge and confirm that areas of my body circled on the diagram below may be touched by the RMT during the course of my treatments:



I acknowledge and understand that it may be necessary for the RMT to adjust their treatment plan during my treatment, in which case they will discuss that with me.

Signature of Patient*: _____ Date: (dd/mm/yyyy): ___/___/_____.
(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case the Name & Relationship of Person Signing: _____.)