A Touch of Balance
106-14271 18A Ave., Surrey, BC V4A 7N8
(604) 788.8946

Consent Statement

My responsibilities as your RMT regarding consent:

1. Engage you in a shared decision-making about your treatment plan, goals and expectations.
2. Respect your autonomy.
3. Act with integrity, and in your best interest.
4. Obtain consent before each assessment, treatment and re-assessment.
5. Discontinue treatment if you withdraw consent.
6. Give you enough information that you can make an informed decision about receiving massage therapy.
7. Provide you with copy of this consent at your request.
8. Remain aware and responsive to questions that you may have.
9. Seek feedback during treatment, and modify if needed, in response to verbal or non-verbal indications or pain or discomfort.
10. Be compliant with the Health Care and Care Facility Act and infants Act.

With Regards to responsibility number six, I will

a. describe the proposed assessment/ treatment/ home care when we talk at the beginning/ end of each session,
b. confirm which areas we agree upon to be touched, and what products (if any) I will use,
c. Provide information about the anticipated benefits and possible negative effects of the treatment;
   i. some general gegative effects of massage could be: bruising, aching, discomfort, short term aggravation of symptons, and skin irritation,
   ii. some general positive effects of massage could be: decreased pain, reduced muscle spasm, decreased muscle stiffness, improved function/range of motion, lessening of anxiety and stress, promotion of relaxation, reduction of the symptoms of depression, improved sleep.
d. give you the therapeutic rational for the proposed treatment, provide you alternationves to treatment, and refer you other health professionals if appropriate,
e. Provide you options for disrobing, please note that you do not have to disroe at all if you choose,
f. Explain options for draping during your treatment,
g. Communicate with you in a clear manner.

Your responsibilities as my patient:

1. Ask questions when you have them,

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2. Inform me if your health condition changes at all so that I may adjust your treatment plan accordingly,
3. Let me know if something is uncomfortable so I may adjust what I am doing.
4. Engage me in a discussion about your goals and expecations, what you feel duringtreatment, and how you react to treatment,
5. Understand that ultimately decisions about my health care are my choice, and that I may withdraw my consent verbally at any point during the treatment for any reason.

Alternatives to Registered Massage Therapy treatment may include consulting other health professionals. Your Massage Therapist may also prescribe rest without treatment, or exercise with or without treatment.

I give consent to my RMT undraping the following areas during treatment

- ☐ ALL necessary areas listed here
- ☐ shoulders
- ☐ back
- ☐ glutes/ buttocks (1 side at a time)
- ☐ pectorals
- ☐ breast(s) (1 side at a time)
- ☐ abdomen (with chest/breast drape)
- ☐ arms/ axillary
- ☐ legs

I give consent to my RMT assessing and treating the following areas

- ☐ ALL necessary aread listed here
- ☐ All areas except bex(s) See notes below to elaborate
- ☐ Head/ scalp
- ☐ Face
- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Back
- ☐ Gluteals (buttocks)
- ☐ Hips
- ☐ Pectorals (chest wall muscles)
- ☐ Breast(s)
- ☐ Abdomen
- ☐ Arms/ axillary
- ☐ Forarm
- ☐ Hands
- ☐ Thighs
- ☐ Knees
- ☐ Legs
- ☐ Feet

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Please inform RMT of any areas you DO NOT want treatment on. For this and future treatments.

I consent