The Health Centre at the King West Club

266 King St West, Toronto ON, M5V 1H8

www.cardiogo.ca•416.913.9123 (ext. 4)

CONSENT TO REGISTERED MASSAGE THERAPY TREATMENT

I, the undersigned (the "Patient"), hereby consent to massage therapy treatment (the "Treatment") by the Massage Therapist at Cardio-Go's Health Centre at the King West Club (the "Club"). All information in my file will be kept confidential, although, subject to my prior consent, my file may or will be shared among treating therapists and/or between the professionals in order to facilitate that the utmost quality and care is received. I understand that I will not be asked to remove any clothing above and beyond my personal level of comfort and that only the area of Treatment may be uncovered at any given time. I understand that I can, at any time, alter or change anything the Massage Therapist is doing, or stop the Treatment completely for any reason if I so choose.

Mechanical modalities include but are not limited to: interferential current (IFC), muscle stimulation (NMES), Transcutaneous electric nerve stimulation (TENS), ultrasound, cold LASER therapy, and ice therapy. Treatment is guaranteed to be supervised by the Registered Massage Therapist and will be performed and monitored only by a qualified Registered Massage Therapist.

The Patient agrees to communicate all of my questions and concerns regarding the Treatment to the Massage Therapist, especially any concern that my well-being is being compromised. The Registered Massage Therapist has explained and I am aware that I may experience possible side effects from the Treatment, such as temporary discomfort within muscles (24 – 48 hours post-treatment), bruising and temporary dizziness.

The Massage Therapist has explained the following to the Patient:

- the nature, purpose and expected benefits of the Treatment;
- the material risks and any potential side effects of the Treatment;
- alternate courses of action available to me;
- any likely consequence to me not receiving the Treatment.

The Patient has asked any and all questions I have concerning the Treatment and the Massage Therapist has answered all of the questions to the satisfaction of the Patient.

PLEASE NOTE! A missed appointment without 24-hour notice of cancellation will be billed to your account.

Patient's Name (*Please print*)

Name of Registered Massage Therapist (*Please print*)

Signature of Patient

Date Signed

Please be prepared listen to a brief explanation of the Treatment to be performed from your Registered Massage Therapist.

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WAIVER AND RELEASE

The Patient agrees to abide with and keep and obey all rules and regulations now in force or in the future prescribed by The King West Club during the course of the assessment and Treatment to be performed by the Registered Massage Therapist at Cardio-Go's Health Centre at the King West Club (the "Club").

The Patient expressly states hereby that he/she will be voluntarily receiving the assessment and Treatment referred to in the Patient's Intake form and the Informed Consent to which this waiver and release is attached and the Patient hereby assumes all risks of injury or every nature whatsoever with might result from the receipt of such assessment and Treatment at the Club. The Patient hereby waives and releases any and all claims that he/she has or may have against the Club, its employees or agents for injury sustained by the Patient as a result of the receipt of the assessment and Treatment to be performed by the Registered Massage Therapist. The Patient hereby acknowledges that he/she has carefully read this waiver and release and fully understands that it is a waiver and release of liability of the Club and agrees that such a waiver and release is reasonable and proper based on the nature of the Club's business.

The Patient hereby waives and releases the Club from any claims of every nature or kind whatsoever that he/she may have against the Club with respect to any loss or theft of personal property in respect of the facilities operated by the Club.

_____

Patient's Name (*Please print*)

_____

Signature of Patient

_____

Date Signed