Evidence based care

TREATMENT CONSENT FORM

☐ I hereby grant full treatment consent to Achieve Health's RMTs, for the purposes of Massage Therapy treatment. I understand that this may require the removal of clothing items to facilitate access to areas of the body requiring treatment. I also grant permission to Achieve Health to contact my Medical Doctor regarding concerns directly related to my Massage Therapy treatment.

☐ The information provided is true to the best of my knowledge. If there are any changes to my medical history, I understand that it is my responsibility to inform the clinic.

☐ **Fee Policy:** Your appointment time is reserved for you. In consideration of your fellow patients and your therapist please allow a minimum of **24 HOURS NOTICE** to change or cancel your appointment. If 24 hours notice is not given, you may be charged the full price of your appointment.

☐ I consent to receive electronic communications via email and text.

Name _____

Signed this _____day of _____

Signature _____

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