- **St. Albert Physical Therapy & Sports Injury Clinic Inc**
- **Dynamic Sports Physiotherapy**
- **Kensington Physical Therapy & Sports Injury Clinic**
- **Fort Physical Therapy & Sports Injury Clinic**

Informed Consent for Massage Therapy

I, ______________________________________, hereby request and consent to the performance of massage therapy on me by the practitioners and individuals at **St. Albert Physical Therapy & Sports Injury Clinic Inc**.

I have had an opportunity to discuss with the therapist and/or the other office or clinic personnel the nature and purpose of the above mentioned therapy and other procedures. I understand that the results are not guaranteed.

I further understand that, as in all health care, in the practice of the aforementioned therapy that there are some risks to treatment, including, but not limited to, muscle strains and sprains. I do not expect the therapist to be able to anticipate and explain all risks and complications to myself, and I wish to rely on the therapist or clinic personnel to exercise judgment during the course of the procedures, which the therapist or clinic personnel feels at the time and based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned therapy procedures. I intend this consent form to cover my entire course of treatment.

Signature of Patient/Client/Guardian__________________________________ Date (mm/dd/yy) ___/___/20___

Assignment of Payment

I hereby appoint the therapists from whom I receive treatment from **St. Albert Physical Therapy & Sports Injury Clinic Inc** as my lawful attorney for the limited purposes of:

1. Requesting and receiving benefits (as defined in the Health Professions Act), which benefits were provided to me by one or more therapists, and for which I, as "beneficiary" under the Act, am entitled to reimbursement pursuant to the Act.
2. Depositing any cheque issued in respect of such benefits, in any financial institution, to the credit of **St. Albert Physical Therapy & Sports Injury Clinic Inc.**

I acknowledge that if the cost of my treatment(s) is not met by the insuring company, e.g. Alberta Health Care, Community Rehabilitation Program, WCB or Third Party payments, I am responsible for any outstanding fee(s), including interest, for any assessment and treatments received.
* Payment is due at time of treatment.*

Please sign below to confirm that you have read, understood and agreed to the above-mentioned information.

Signature of Patient/Client/Guardian__________________________________ Date (mm/dd/yy) ___/___ /20___

Cancellation Policy

Cancellation – 24-hour advance notice is required when canceling an appointment, except in cases of emergency or illness. Cancellations without 24-hour notice will result in a charge for your session, as that time has been set aside specifically for you.

Late – Please arrive on time for your appointment. Time for your appointment has been arranged for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Full payment for your session will be expected.

No Show – Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no show". They will be charged for their missed appointment.

Signature of Patient/Client/Guardian: _________________________________ Date (mm/dd/yy) ___/___ /20___

Print name: _________________________________ Signature of Witness: ______________________________