CONSENT TO TREATMENT

PATIENT NAME: **DOB (DD/MM/YYYY):** / /

Please read this document, including **Schedule A**. Ask your RMT any questions you have regarding the contents of this form before you sign. You are encouraged to ask questions about your treatment at any time.

TO BE COMPLETED BY PATIENT

Disclosure of Medical History

- 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.
- The information disclosed by me is true and complete to the best of my knowledge.
- If my condition should change, I will notify my RMT before subsequent treatments.

_____ My initials indicate that I understand.

TO BE COMPLETED BY PATIENT WITH RMT PRIOR TO TREATMENT

Treatment Plan

- My goals for my treatment;
- the therapeutic rationale for the proposed treatment;
- possible alternative methods of treatment;
- the anticipated benefits and possible negative effects of the treatment, examples of which include bruising, aching, discomfort, short term aggravation of symptoms, skin irritation and/or

_____

_____

- the areas of my body where treatment will be delivered
- my options for disrobing; and
- my options for draping during the treatment.

_____ **Before signing this form**, my RMT discussed the above elements of the Treatment Plan with me.

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:

_____

_____

Consent to Treatment:

- I consent to the RMT performing the treatments described to me in the Treatment Plan.
- I understand 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 my RMT may need to amend the Treatment Plan.
- If I have concerns during treatment, I will advise my RMT **immediately**.

_____ My initials indicate that I understand.

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) __ / __ / _____

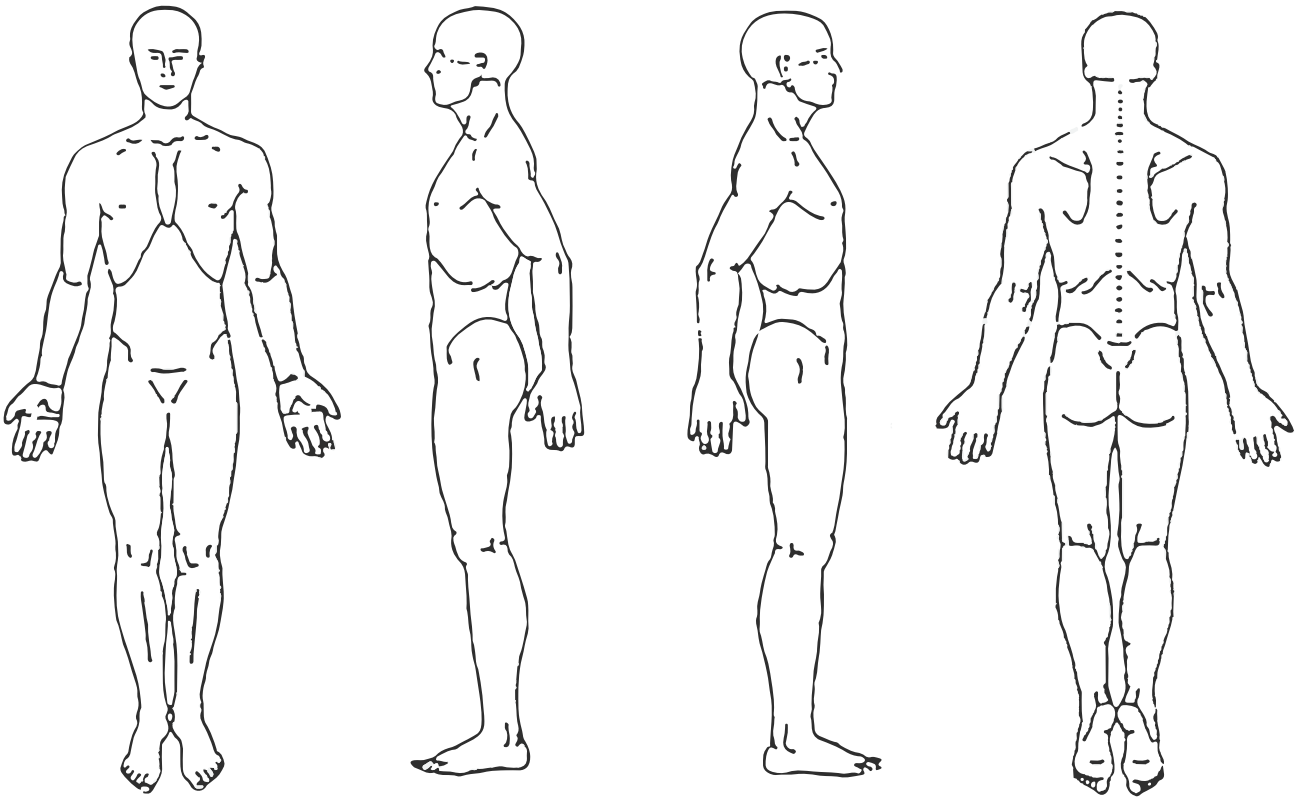
(* In the case of a person incapable of providing consent, signature of Parent or Guardian, in which case
the Name & Relationship of Person Signing: _____.)

SCHEDULE A
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** document previously signed by me and also applies to this treatment on this date.
I consent that the areas of my body circled on the diagram below may be touched by the RMT during my treatments:



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: _____.)