



Achieve Health

Registered Massage Therapists

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.

Name _____

Signed this _____ day of _____

Signature _____

Achieve Health
Chiropractic / Naturopathic / Massage Therapy /
Acupuncture