INFORMED CONSENT FOR TREATMENT AND WAIVER

(Massage Therapy)

Massage therapy involves manipulation of the soft tissues and joints of the body, and the approach to treatment may vary depending upon the patient's conditions. At any time, before or during the massage therapy treatment, the patient has the right to ask that the treatment, or portions of the treatment, be discontinued, or inquire about the purpose of any technique being used. If at any time the patient has questions or concerns related to the treatment, we encourage you to communicate with a massage therapist so there may be clarification or modification of the treatment.

I understand that receiving a treatment during COVID-19 pandemic poses risks and there are no guarantees that I may not come into contact with COVID-19.

Part 1: COVID-19 Assessment:

I confirm that I have taken and will be taking for future sessions, a COVID-19 assessment survey, provided to me separately, a day prior to my appointment and on the day of the appointment. I hereby confirm that all answers were truthful and to date. **I, as a patient,** for my RMT at this clinic, and those of others, if I have answered "YES" to ANY of the questions in **Covid-19 Assessment Survey**, I agree that for my safety, and those of others, I cannot attend my RMT appointment, and I will cancel my appointment immediately. I will take all necessary steps recommended by https://bc.thrive.health/covid19/en

If I have answered "NO" to ALL the statements in **COVID-19 assessment survey**, I confirm that

- I will cancel my appointment(s) immediately if/when any of the above answers' change.
- I also must follow 14 days quarantine before I can be assessed again prior to my bookings.
- I understand that late cancellation fees will NOT apply for any cancellations related to COVID-19.

Initial ______

Part 2: Concerns of Immune-Compromised Persons:

Yes / No	Are you over 65 years of age, and experiencing any of the following: delirium, falls, acute functional decline, or worsening of chronic conditions?

Yes / No	Do you consider yourself immune-compromised / immuno-sensitive person?
Yes / No	Do you currently have serious underlying medical conditions?
Yes / No	Are you currently taking care of someone who is immune-compromised / immune-sensitive?

If ANY of the answers is YES to the above questions, knowing that you or the persons around you might be at higher risk for severe illness from COVID-19, you voluntarily confirm (circle your answer and put initial besides it):

- **"Yes.** I confirm that I will still seek massage therapy at this time".
- **"No.** I am voluntarily stopping my RMT treatments for now".
- **"Not Applicable**. I consider myself healthy. All of my answers are NO to **Part 1**".

Intial ______

Part 3: I, as a patient, for my safety, for my RMT at this clinic**,** and those of others, agree to:

Yes / No	wear a mask or facial coverings during my visit; and
Yes / No	sanitize my hands upon entry/re-entry into my RMT Clinic and promptly after my treatment is finished; and
Yes / No	wait in my vehicle or outside, and only come in 5 mins before my appointment time; and
Yes / No	only come to the clinic ALONE, unless I physically require a caregiver or a guardian; and
Yes / No	only come with minimum personal belongings to help prevent cross contamination and prevent the spread of COVID-19; and
Yes / No	strictly follow the 6 feet physical distancing rules to help maintain the safety of myself and the others in the clinic; and
Yes / No	leave promptly after my appointment; and
Yes / No	read the new protocols and follow all of the necessary steps to protect myself and anyone in this clinic, to help prevent the spread of COVID-19; and
Yes / No	anyone who comes into the clinic with me has to follow ALL of the protocols like I do, including but not limited to wearing a facial covering throughout, hand sanitizing, physical distancing, filling out **COVID-19 Patient Intake Consent** prior to entering the clinic.

If I have answered "NO" to ANY of the statements in **Part 3**, for my RMT and their family's health concerns, and those of others, I agree to be referred to other RMTs or other clinics.

Initial ______

Part 4: I, as a patient, of my RMT at this clinic**,** if I have answered "YES" to ALL of the above statements in **Part 3**, I understand and agree with:

Yes / No	COVID-19 virus has a long incubation period whereby carriers of the virus may not show symptoms and can still be contagious; and
Yes / No	due to the visits of other patients, or simply by being in this clinic / building, I have elevated the risk of contracting COVID-19; and
Yes / No	while my RMT is following all of the health and safety guidelines outlined by The Registered Massage Therapists Association of BC, the College of Massage Therapists of BC, and the Provincial Health Officer and that they are taking all reasonable precautions to clean and disinfect the clinic and all the surfaces within the treatment room, there are no guarantees that I may not come into contact with COVID-19; and
Yes / No	I am fully aware of and fully responsible of any allergic reactions may arise due to my exposure of government approved disinfectants at this clinic; and
Yes / No	I may discontinue the Registered Massage Therapy treatment(s) at any point of time when I do not feel safe to do so; and
Yes / No	for me to receive Massage Therapy Treatments, my RMT will not be able to practice social distancing.

If I have answered "NO" to ANY of the statements in **Part 4**, I agree that I am not seeking RMT treatment at this time at this location.

Initial ______

Part 5: I, as a patient, of my RMT at this clinic, if I have answered "YES" to ALL of the above statements in **Part 5**, I voluntarily:

Initial	agree to sign this form truthfully ; and
Initial	give my RMT permission to contact me directly the day before my upcoming appointments, and I will truthfully answer questions in Part 1 of this consent form each time; and
Initial	release my Registered Massage Therapist and the Clinic of any

	liability if I were to contract COVID-19; and
Initial	agree to immediately notify clinic management and the therapist if I am diagnosed with COVID-19 or have its associated symptoms to inform of the positive result and possible transmission
Initial	give this clinic my permission to share my personal information for contact tracing when there is a confirmed positive.
Initial	give my RMT the right to refuse to provide treatment when it is not safe for me to receive or not safe for RMT to perform treatment.

Part 6: Acknowledgment and Disclaimer:
The information listed on this page is based on current recommendations from health and safety regulatory bodies. The content is subject to change due to the unknown characteristics of the COVID-19 and the global pandemic. New signature is required when newer Consent Form is introduced.

I, ____, as a patient at this clinic,

I verify that the information I have provided on this form is truthful and accurate. I have read and fully understand and agree to follow ALL the above details. I understand that ANY massage therapy treatment involves some risk of COVID-19 transmission. I weigh my ongoing RMT treatments as medically necessary during this COVID-19 pandemic, I voluntarily give the consent to receive on-going massage therapy treatment(s) during this COVID-19 pandemic.

I understand I have the obligation to disclose all medical condition, medications currently being taken or taken within the last twelve months, and all health related concerns in order to minimize the risk of side-effects or adverse reactions to treatment. I understand that my practitioner is relying upon information provided by me to determine the most appropriate form of treatment for me. I also understand that individual reactions may vary and Medspa Health Center Ltd. cannot guarantee the success of any particular treatment, nor can it guarantee that I will not suffer adverse side-effects. This agreement limits your ability to see damages from Medspa Health Center Ltd. in the event of adverse reaction to such treatments.

I hereby waive any claim I, or any person acting through me or on my behalf, may have against Medspa Health Center ltd., its officers, directors, owners, employees, agents or assigns, whether at law or in equity, arising from or in any way related to damages, losses, costs or any other cause whatsoever, and wherever arising, sustained by me as a result of the treatments performed on me by Medspa Health Center Ltd's associates. I

expressly release Medspa Health Center Ltd., its officers, directors, owners, employees agents and assigns from all liability with respect to any such claim.

I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of sixteen, but no more than sixteen years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

Please sign below that you understand the above information you have provided in this case history is accurate. Signing will also indicate your consent to treatment.

Signature: ______________________ Date: ________________________

Guardian (if under 18 years): _______________________