2221 Keele Street, Suite 302
Toronto, ON M6M 3Z5
Phone:416-759-8099
Fax:416-759-9085
www.iwellness.ca

FEE SCHEDULE
FOR MASSAGE THERAPY

Adult Fees

30 Minute Massage ($55.00 + $7.15 HST) $62.15

45 Minute Massage ($75.00 + $9.75 HST) $84.75

60 Minute Massage ($90.00 + $11.70 HST) $101.70

75 Minute Massage ($105.00 + $13.65 HST) $118.65

90 Minute Massage ($125.00 + $16.25 HST) $141.25

60 Minute Hot Stone Massage ($110.00 + $14.30 HST) $124.30

Senior or Student Fees

30 Minute Massage ($50.00 + 6.50 HST) $56.50

45 Minute Massage ($70.00 + 9.10 HST) $79.10

60 Minute Massage ($85.00 + 11.05 HST) $96.05

75 Minute Massage ($100.00 + 13.00 HST) $113.00

90 Minute Massage ($120.00 + 15.60 HST) $135.60

All patients will receive a receipt at the end of the visit schedule for their records and/or submission to a third party insurance company. All fees include HST.

I agree to the fees explained to me as stated above.

______________________________ ____________________

Patient Name (Print) **Date:**

____

Patient Signature

Please note that 24-hour appointment cancellation notice is required to avoid charges.

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Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name:________________________________ ***Signature:***__________________________
Mobile Phone:________________________
Address: ____
City: ________________ **Prov.:**____________________ **Postal Code:**___________
Occupation:___________________________ **Date of Birth:**___________________________
Email Address: ____
The e-mail address is for the purpose of our communication with you and will not be used or sold for any reason.

Have you received Massage Therapy Before? ☐ **Yes** ☐ **No**
How were you referred to the clinic? ____

Please indicate conditions you are experiencing or have experience:

Is there a family history of heart problems ? ☐ Yes ☐ No **Respiratory** □ Chronic Cough □ Shortness of breath □ Bronchitis □ Emphysema Is there a family history of respiratory disease? ☐ Yes ☐ No **Head/Neck** □ History of headaches □ Vision problems □ Ear problems □ Hearing loss	**Infection** □ *skin conditions* □ *TB* **Other Conditions** □ Loss of Sensation, where?________ □ Diabètes, onset:_______________ □ Allergies /hypersensitivity to what? _____________________________ Type of reaction:________________ □ epilepsy □ skin conditions, what? __________ Is there a family history of any of the above? ☐ Yes ☐ No	**Women** □ Pregnant ,due: ___________ □ Gynecological conditions, What? ___________________________ Overall, how is your general health? ___________________ Primary Care Physician: ___________________________ Address:_________________ ___________________________

Current Medications: ___________________ Conditions it treat: _____________________ Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No If yes, for what? ____________________ Surgery -date______________________ Injury- date ________________________	Do you have any other Medical conditions (e.g digestive conditions, hemophilia, osteoporosis, mental Illness) ☐ Yes ☐ No what? ____ Do you have any internal pins, wires, artificial joints or special equipment? ____ What? ____ Where? ____ What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort. ____

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INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I hereby consent to the therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by the therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by the therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/ from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by the therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw, my consent and treatment will be stopped.

Patient Name: ______________________________

Signature of Patient: ______________________________

Witness:____________________________

Date Signed: _______________________

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