

GJ-TCM Clinic Center

10 East Wilmot St, Unit 6, Richmond Hill, ON L4B 1G9

Phone: 905-731-6555 | www.gjtcn.ca

PART ONE – Patient Informed Consent to Treatment

I, _____ [name of patient or substitute decision-maker (SDM)], consent to have _____ [name of practitioner] perform the following treatment(s):

Describe specific treatment or plan of treatment (e.g., Traditional Chinese Medicine assessment and diagnosis, Acupuncture, Moxibustion, Cupping, Gua Sha, Tuina massage, Herbal prescription, auricular therapy, Registered Massage Therapy (RMT), or other modalities):

I acknowledge that my practitioner has explained the following to me:

- • The nature of the treatment, as set out above
- • The material risks and potential side effects of the treatment
- • The alternatives to having the treatment
- • The likely consequences of not having the treatment
- • That results cannot be guaranteed
- • That I have provided accurate and complete health history information
- • That I can withdraw or alter my consent at any time

I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third-party insurance.

By signing below, I acknowledge that I have discussed this consent form with my practitioner, had the opportunity to ask questions, and that I voluntarily give my informed consent for the treatment described above.

Patient/SDM Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

PART TWO – Consent for Assessment and Treatment of Sensitive Areas

I, _____ (name), have requested assessment and/or treatment by this TCMP Practitioner or Registered Massage Therapist (RMT) _____ (name) for treatment of the clinically relevant areas indicated below (please initial):

_____ Buttocks (gluteal muscles)

_____ Chest wall muscles

_____ Upper inner thigh(s)

_____ Breast(s)

The RMT has explained and I fully understand the proposed assessment and/or treatment, including:

- • The nature of the assessment and the clinical reasons for treating the area(s) listed above
- • The draping methods to be used
- • The expected benefits and potential risks or side effects
- • That consent is voluntary and may be withdrawn or altered at any time

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Ongoing Treatment Consent

I acknowledge that treatment of the above area(s) is part of an ongoing treatment plan discussed with my RMT. I provide my informed consent for continued treatment on the dates below:

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

GJ-TCM Clinic Center

10 East Wilmot St, Unit 6, Richmond Hill, ON L4B 1G9

Phone: 905-731-6555 | www.gjtcn.ca

PART ONE – Patient Informed Consent to Treatment

I, _____ [name of patient or substitute decision-maker (SDM)], consent to have _____ [name of practitioner] perform the following treatment(s):

Describe specific treatment or plan of treatment (e.g., Traditional Chinese Medicine assessment and diagnosis, Acupuncture, Moxibustion, Cupping, Gua Sha, Tuina massage, Herbal prescription, auricular therapy, Registered Massage Therapy (RMT), or other modalities):

I acknowledge that my practitioner has explained the following to me:

- • The nature of the treatment, as set out above
- • The material risks and potential side effects of the treatment
- • The alternatives to having the treatment
- • The likely consequences of not having the treatment
- • That results cannot be guaranteed
- • That I have provided accurate and complete health history information
- • That I can withdraw or alter my consent at any time

I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third-party insurance.

By signing below, I acknowledge that I have discussed this consent form with my practitioner, had the opportunity to ask questions, and that I voluntarily give my informed consent for the treatment described above.

Patient/SDM Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

PART TWO – Consent for Assessment and Treatment of Sensitive Areas

I, _____ (name), have requested assessment and/or treatment by this TCMP Practitioner or Registered Massage Therapist (RMT) _____ (name) for treatment of the clinically relevant areas indicated below (please initial):

_____ Buttocks (gluteal muscles)

_____ Chest wall muscles

_____ Upper inner thigh(s)

_____ Breast(s)

The RMT has explained and I fully understand the proposed assessment and/or treatment, including:

- • The nature of the assessment and the clinical reasons for treating the area(s) listed above
- • The draping methods to be used
- • The expected benefits and potential risks or side effects
- • That consent is voluntary and may be withdrawn or altered at any time

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Ongoing Treatment Consent

I acknowledge that treatment of the above area(s) is part of an ongoing treatment plan discussed with my RMT. I provide my informed consent for continued treatment on the dates below:

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____