SOURCE CENTRE GENERAL POLICIES

On your first visit, it is required that you fill out health history forms which should be updated yearly with any address or health changes that your practitioner should be aware of. Your practitioner will review this information with you and ask questions to ensure that you receive the treatment that meets your needs. Ongoing progress reports will be attached to your file on a regular basis.

Cancellation/Missed Appointment Policy

If you are unable to make an appointment, we request that you call 24 hours in advance. If you do not call to cancel or if you do not show up for your appointment, a cancellation fee will be charged. The fee for cancellations is equal to 50% the normal rate. If you book within the 24hr time frame, this policy becomes effective immediately. ***All cancellation fees are subject to HST.*

Lateness Policy

Your appointment reserves the specified time for your visit (60 minutes, 90 minutes etc.). If you arrive late for your appointment, you will be charged the full amount of your booked appointment but only receive treatment equal to the time remaining.

Cell Phones/Pagers within the Centre

Please understand that to achieve an environment of quiet and relaxation we ask that you turn off your cell phone, pager or other electronic devices.

Email Etiquette and Consent

We strive to keep in touch with our clients by all media available, the most common of which being Email. We ask that you keep the following in mind when using email to communicate with us:

1. E-mail is not appropriate for urgent or emergency problems, including last minute cancellations.
2. E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
3. E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee. If you do not receive a response, do not assume that we have actually received the message.
4. There is no way to assure the privacy of e-mail on a shared computer or e-mail account.
5. All e-mail correspondence will become a part of your medical record at the clinic.
6. It is extremely important to include your name and the name of your practitioner on every e-mail sent to the Source Centre.

By signing this document, you are confirming that you have read and understood the above information about the use of email to communicate matters pertaining to your health and healthcare, and understand the issues inherent in this use.

Consent to Terms of Services (Summary)

Providing you with the highest level of service is our business and we take this very seriously. Please take a minute to review our Terms of Services on our website so you are aware of what you may expect from us. In order for us to ensure you receive the highest level of care, we ask that you respect these Terms.
http://www.sourcecentre.ca/about/more/terms-service/

Privacy Policy Consent

As of January 1st, 2004, the Canadian Federal Government's Personal Information Protection and electronic Document Act (PIPEDA), was created. This privacy law requires your knowledge and consent before we may collect your personal information, except in rare circumstances. This means we want you to understand what we do with personal information we obtain about you. Our full Privacy Policy is available at your request and is posted on our web site at http://www.sourcecentre.ca/about/more/privacy/

Collection of Personal Information (Summary)

In order to provide you a health service we must collect some personal information, including but not limited to: telephone number, address, occupation, health history, prescriptions, involvement in other healthcare, etc. This information will be kept strictly confidential and will not be disclosed to any third party with the exception of the following: with your direct written consent, a medical emergency while you are on the premises, when required by law (i.e. court subpoena) or during regulated healthcare assessment purposes for quality assurances.

Please review our full Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. If you have any questions or concerns about the Privacy Policy, it is your responsibility to address them immediately with your practitioner.

Sharing of Personal Health Information with other Source Centre Practitioners

I consent to Source Centre practitioners, whose care I am under, sharing personal health information amongst themselves with regards to my care, for the purpose of enhanced clinical outcomes Y ❍ N ❍

By signing this Source Centre General Policy form, you are indicating that you have read and consented to all of these policies and that you have had a chance to read, and agree to, our Privacy Policy and our Terms of Service. If there is anything you do not understand in any of the above, please talk to us immediately.

I agree that I have read and understood all the policies, and I have been given a chance to ask any questions I have about the Privacy Policy and Terms of Services and that they have been answered to my satisfaction.

Signature _____

Client Name _____ Date_____

Signature of parent or Guardian (for anyone under the age of 18):

Signature _____

Guardian/Parent Name _____ Date_____

SOURCE CENTRE
HEALTH IN WHOLENESS

Source Centre for Health and Wellness
202 – 326 Adelaide St. W. Toronto, ON, M5V 1R3
416 923-4325
www.sourcecentre.ca

Date_____

HEALTH HISTORY FORM for MASSAGE THERAPY

For your information:
An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law, or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

First Name: _____ Last Name: _____ Mr. ___ Mrs.___ Ms. ___

Address: _____ Postal Code: _____

Phone: Home: _____ work: _____x: ____ cell: _____

e-mail: _____Occupation: _____ Date of Birth: _____

Primary Concern/Complaint? _____

Who may we thank for referring you?

Health History: Please indicate conditions you are experiencing, or have experienced in the past:

GENERAL • headaches/migranes • dizziness • fatigue • fibromyalgia • chronic fatigue syndrome • seasonal allergies	**RESPIRATORY** • chronic cough • bronchitis • emphysema • asthma	**CARDIOVASCULAR** • high/ low blood pressure • phlebitis • heart / disease / attack • stroke / CVA • pacemaker • chronic congestive heart failure	**SKIN** • sensitive • bruise easily • eczema • varicose veins • psoriasis • infectious conditions:
HEAD/NECK • vision problems • ear problems • vertigo • sinus **ALLERGIES (please list):**	**WOMEN** • menstrual problems • menopausal problems • pregnant (due_____) **MEN** • prostate cancer • testicular cancer	**COMMUNICABLE DISEASES** • TB • Hepatitis • HIV	**OTHER** • cancer • arthritis OA • arthritis RA • epilepsy • hemophilia • diabetes – onset_____

SOFT TISSUE/JOINT DISCOMFORT

- neck _____
- shoulders _____
- upper back _____
- lower back _____
- arms _____
- legs_____
- other _____

Special Note of any Pins, Wires, artificial joints:

Current Medications: _____ _____

Condition being treated: _____ _____

Physician _____

Surgery _____ **Date**_____

Injury _____ **Date** _____

Other Healthcare Treatment _____

I understand and agree that the following information on this form is accurate, current and will be confidential.
I consent to massage therapy treatment and have discussed with the therapist the nature and purpose of therapeutic massage. I understand and am informed that, as in all healthcare, there are some risks to treatment which, if applicable, will be discussed before the treatment.

_____
Signature

_____
Date

ONGOING CLINICAL RECORD

CLIENT NAME: _____

Date: _____ **Therapist:** _____ **CTT** ☐ **CTA** ☐

Appointment Time:_____am/pm **Duration:**_____minutes **Fee:** $_____

Subjective: ☐Relax ☐Tx ☐Maintenance

Assessment/Clinical Findings:

Areas Treated: ☐back ☐neck ☐shoulder ☐chest ☐head ☐face ☐arm L/R ☐hands ☐legs L/R ☐hip area ☐feet ☐abs ☐breast ☐FB

Techniques Used: light/mod/deep P ☐Swedish ☐MFR ☐TrP ☐joint mob ☐hydro ☐GTO ☐M stripping ☐rhythmic ☐CST ☐LD ☐frictions ☐breast massage ☐intra oral ☐stretch:_____

Reassessment/Client Feedback: ↓ ↑ % of Δ ____ ☐looser ☐more relaxed ☐light headed ☐compliant to Remex

Treatment Plan/Self Care: Txs:____xs per week/biweekly/month for____mins for_____weeks/month/ongoing ☐PRN ☐ESB ☐Hot shower ☐RICE ☐Postural Techniques ☐Breathing Techniques ☐Stretches/Strengthening:_____

Referral: ☐MD ☐DC ☐DOMP ☐PT ☐DAC ☐CST ☐RMT ☐ND

Date: _____ **Therapist:** _____ **CTT** ☐ **CTA** ☐

Appointment Time:_____am/pm **Duration:**_____minutes **Fee:** $_____

Subjective: ☐Relax ☐Tx ☐Maintenance

Assessment/Clinical Findings:

Areas Treated: ☐back ☐neck ☐shoulder ☐chest ☐head ☐face ☐arm L/R ☐hands ☐legs L/R ☐hip area ☐feet ☐abs ☐breast ☐FB

Techniques Used: light/mod/deep P ☐Swedish ☐MFR ☐TrP ☐joint mob ☐hydro ☐GTO ☐M stripping ☐rhythmic ☐CST ☐LD ☐frictions ☐breast massage ☐intra oral ☐stretch:_____

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Referral: ☐MD ☐DC ☐DOMP ☐PT ☐DAC ☐CST ☐RMT ☐ND