M.T. Wellness Clinic
Patient Acknowledgements and Agreements

Please initial after reading each of our clinic policies:

_____ Payment is due at the time of service upon check in for your appointment. We accept cash, check or credit (Visa and MasterCard ONLY). Sales tax exemptions are available for patients with a medical prescription. A $35 fee will be assessed for returned checks.

_____ We require a 24-hour cancellation notice for all appointments. Failure to do so will result in an assessed fee equal to the cost of the appointment.

_____ Medical receipts are available upon request. These may be useful for Health Savings Accounts or Flexible Spending Accounts.

_____ Costs for medical record copies made upon request by the patient or the patient's personal representative are charged in accordance with Ohio Revised Code 3701.741.

_____ The M.T. Wellness Clinic uses the team approach by matching you with therapists who can best delivery the care you need. During the course of your treatment, you may be seen by more than one therapist who would collaborate on your care. All of our therapists are massage therapists licensed through the State Medical Board of Ohio. We will do our best to accommodate requests for a specific therapist.

_____ The M.T. Wellness Clinic is involved in the training of new Certified Medical Restorative Massage Therapists and may permit these therapists to observe and participate in your treatment, including, where appropriate, providing direct treatment to you under your therapist's direct supervision. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

_____ As our patient, you have the right to: consideration of ethical, cultural, spiritual or psychosocial issues that arise in provision of care; care in a safe and clean setting; privacy and confidentiality according to HIPAA and other medical standards; access information contained in your medical record (medical record charges may apply); participate in decisions involving your care; respect and dignity; file and review of any complaint about your care without fear of penalty.

_____ As our patient, we request you to: provide, to the best of your knowledge, complete information about your pain, symptoms, past illnesses and treatments, medications and other matters relating to your plan of care; ask questions when you do not understand explanations about your care or our services; be responsible for your actions if you refuse treatment or do not follow the plan of care made collaboratively between the M.T. Wellness Clinic and you; be courteous and respectful of the M.T. Wellness Clinic staff and other patients; follow all other M.T. Wellness Clinic policies.

Consent to treat

It is my choice to receive Medical Restorative Massage Therapy ® (MRMT ®) treatments. I understand that this treatment is designed to reduce pain and restore physical function through manual therapies along with treatment aids. I agree to communicate with my practitioner any time I feel like my well-being is compromised. I understand that Certified Medical Restorative Massage Therapists do not diagnose illness, diseases or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals or

perform spinal thrust manipulations. I acknowledge that MRMT is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update my therapist of any changes in my health status as soon as possible.

Release of Information

Name (print): _____ Address: _____

City/State/Zip: _____ Ph: _____

☐ Primary Care ☐ Specialist ☐ Other: _____

Name (print): _____ Address: _____

City/State/Zip: _____ Ph: _____

☐ Primary Care ☐ Specialist ☐ Other: _____

Name (print): _____ Address: _____

City/State/Zip: _____ Ph: _____

☐ Primary Care ☐ Specialist ☐ Other: _____

By signing below, I agree that I have been informed of the M.T. Wellness Clinic's policies stated above concerning my medical and financial responsibilities. I give my permission to the M.T. Wellness therapy staff to provide me with MRMT treatments. I give my permission for the M.T. Wellness Clinic to provide any information that pertains to my MRMT care to the party or parties identifies in the "Release of Information" section above.

_____	_____	_____
Patient name (print)	Patient signature	Date

Rev: 09/25/2015