**Client Consent Form**  **STRICTLY CONFIDENTIAL**

**First Name**:…………………………………………….. **Surname**:………………………………………………. **Sex:………………………**

**Address**:………………………………………………………………………………………………………………………………….

………….………………………………………………………………………………..……………**Postcode:**………………..…..

**Telephone:** **Home:**……………………………………………. **Mobile:**………………………………………………….

**Date Of Birth**:………../……………/……………… **Age**:………… **Occupation**:…………………………………………………………………….

**Activities / Sports**:……………………………………………………………………………………………………………………………………………………….

**EMERGENCY CONTACT:** **NAME:**  **RELATIONSHIP:**

**CONTACT NUMBER:**

**GP Surgery:………………………………………………………………………………… Telephone:…………………………………………..**

**Please Indicate Any Of the Following That Apply To You:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **High / Low Blood Pressure** |  | **Varicose Veins** |  | **Diabetes (Type 1 or 2)** |  |
| **Heart Condition(s)** |  | **Any Blood Disorders** |  | **Allergies / Sensitivities** |  |
| **Deep Vein Thrombosis (DVT)** |  | **Cancer** |  | **Any Surgery (please specify)** |  |
| **Any Other Conditions Please State:** |
|  |
|  |

**Any other information or medical information we should be made aware of**;

……………………………………………………………………………………………………………………………………………………………………………………………………………..………………………………………………………………………………………………………………………………………………………….

**Reason For Visit**:

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Massage / Treatment**:

Are There Any Areas (Face, Abdomen, Feet, etc) you prefer not to be treated? Please specify:

…………………………………………………………………………………………………………………………………………………………………………………….

**Please Circle Areas with Pain / Discomfort:**

**Patient Consent**:

* I understand that deep tissue massage / treatment may result in muscle soreness over the next 24 – 72 hours following treatment, and the use of ice may be necessary if suggested.
* All the information above is true to my knowledge, and if anything changes I will inform the practitioner.
* When paying a block booking I understand that’s failure to attend or cancel with less than 24hours notice there will be no refund, or ability to re-schedule the appointment.
* When paying per session I agree to paying the full massage fee if I fail to attend or cancel the appointment with less than 24hours notice.
* Confirm I have read and understood the content of the consent form
* Consent to undertake the initial assessment and subsequent treatment (if applicable)
* Consent to the therapist storing my personal and medical information, during my referral period and after my discharge
* Consent to the release of personal data and medical records gained from me via a summary / assessment report compiled by the assessing therapist, to referring organisation, insurer and/or third-party representative
* Consent to the release of appropriate medical reports to treating therapists arranged through PC Wellbeing Therapy if it is considered to be beneficial for my treatment
* I am aware of your Privacy Policy and I understand that I may withdraw my consent at any time, without prejudice
* I am aware that my contact details are used to send out reminders/alterations of appointments and for questionnaires and information on our services and that I can opt out of this, without prejudice
* Consents to be treated at this clinic and understands that certain communications will be required as part of that treatment
* I appreciate that although all reasonable steps to reduce risk of infections have been taken, including screening potential Covid-19 cases and undertaking increased hygiene and distancing protocols there may still be a risk of infection from face to face appointment. I knowingly and willing consent for Face to Face appointment to take place.
* The Clinic fully complies with the most up to date Data Protection Policy and has a transparent approach to Data Processing which empowers individuals to know about the collection and use of their personal data. We collect data for ensuring we have the right information for assessing your suitability to treatment, for completing the appropriate treatment, for contacting you regarding appointment follow-ups and for a referral to GP or other healthcare practitioners if deemed necessary. Your data may be viewed by clinic staff to ensure continuity of care is given and for standards clinic running purposes. In addition, the data may also be shared with NHS Trace and Test if required to minimise the spread of Covid-19. We collect only data that is relevant to those purposes, and we keep it for 7 years. All information held will be treated as strictly confidential and will only be released to any other external party with the consent of the client."
* I have read The Clinic’s Data Protection Policy and consent to The Clinic processing records as outlined above and understand that I can withdraw my consent on the processing of data at any time.

**Client Signature: Date:**

**Therapist Signature: Date:**

|  |  |
| --- | --- |
| **Date** | **Notes** |
|  |  |