Myofascial Pain Treatment Center, LLC
203 Arlington Street
Watertown, MA 02472

CONSENT FOR EVALUATION AND TREATMENT

I, _____, understand that the treatments given at Myofascial Pain Treatment Center, LLC are for the purpose of relief from musculo-skeletal pain, tension and/ or spasm. I understand that Erika Bourne, RN and Yvan Riendeau, LMT do not diagnose illness, disease, or any other physical or mental disorder.

Manual Myofascial Trigger Point Therapy includes: manual trigger point therapy, myofascial stretching, corrective exercises, ergonomic, posture and self-care training.

It has been made clear to me that this myofascial therapy is not a substitute for medical examination and/or diagnosis and it is recommended that I see a physician for medical conditions revealed on the Medical History Form or any other physical ailments I may have. I have stated all of my medical conditions and symptoms on the Medical History Form and take it upon myself to keep Erika Bourne, RN and/or Yvan Riendeau, LMT at Myofascial Pain Treatment Center, LLC updated about my physical health.

Side effects from treatment may include bruising, muscle soreness, swelling or tenderness for a period of time (usually no longer than 24-48 hours) after treatment. I understand that I can refuse treatment at any time and that I have the right to bring someone of my choosing to accompany me into the treatment room for my piece of mind, if I wish to do so.

I understand that all information shared with Myofascial Pain Treatment Center, LLC is confidential and no information will be released without my written consent. Photographs or other images of me may be used for evaluation purposes and to keep a record of my care and treatment. These images will become part of my medical record and are strictly confidential.

I understand that I am responsible for all charges incurred, regardless of my insurance status and I agree to pay for services as I incur the charges. I understand and agree that appointments cancelled with less than 24 hours notice will be charged the appointment fee.

By voluntarily signing below, I acknowledge that I consent for evaluation and treatment. I have been told about the risks and benefits of trigger point therapy and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from Erika Bourne, RN and/or Yvan Riendeau, LMT at Myofascial Pain Treatment Center, LLC.

Patient Signature_____ Date____/_____/_____