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 does not diagnose illness, disease, or any other physical or mental disorder.

Manual therapy offered includes: manual trigger point therapy, fascial manipulation, soft tissue techniques, myofascial stretching, corrective exercises, ergonomic, posture and self-care training.

It has been made clear to me that this 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 at Myofascial Pain Treatment Center, LLC updated about my physical health.

Side effects from treatment may include bruising, soreness, swelling or tenderness for a period of time (usually no longer than 24-48 hours) after treatment. I understand that the soreness from treatment occasionally can last for a longer duration. 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 at Myofascial Pain Treatment Center, LLC.

Patient Signature_____ Date____/_____/_____

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HIPAA

Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Erika Bourne, RN for the purpose of evaluating and/or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Erika Bourne, RN. I understand that evaluation and/or treatment of me by Erika Bourne, RN may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Erika Bourne, RN is not required to agree to the restrictions that I may request. However, if Erika Bourne, RN agrees to a restriction that I request, the restriction is binding on Erika Bourne, RN.

I have the right to revoke this consent, in writing, at any time, except to the extent that Erika Bourne, RN has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Myofascial Pain Treatment Center, LLC and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Erika Bourne, RN. The Notice of Privacy Practices for Myofascial Pain Treatment Center, LLC is also posted in the waiting room at 203 Arlington Street, Watertown, MA. This Notice of Privacy Practices also describes my rights and duties of the Erika Bourne, RN with respect to my protected health information.

Myofascial Pain Treatment Center, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Erika Bourne, RN and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Name (print) _____

Signature of Patient _____

Date of Signing_____