Consent Form for Myofascial Release

Client Information

- Name: _____
- Date of Birth: _____
- Contact Number: _____
- Email Address: _____

Emergency Contact Information

- Name: _____
- Relationship: _____
- Contact Number: _____

Consent for Myofascial Release Therapy

I, _____ (Client's Name), hereby consent to receive Myofascial Release therapy (MFR) at the Pilates Center of Austin.

Understanding and Acknowledgment

- I acknowledge that the practitioner will use gentle sustained pressure and stretching to facilitate the release of fascial restrictions.
- I understand that Myofascial Release is not a substitute for medical treatment or diagnosis, and I should consult with my healthcare provider for any medical concerns.
- I acknowledge that while Myofascial Release is generally safe, it may cause some discomfort or soreness during and after the session.

I voluntarily agree to assume all of the foregoing risks and furthermore accept sole responsibility for any injury (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my presence or participation at The Pilates Center of Austin. I recognize that many changes may occur as a result of these exercise lessons, including possible short-term aggravation of some symptoms, feelings of tiredness, lightheadedness, increased energy, mood changes, etc. I agree that The Pilates Center of Austin shall not be liable for any injuries or damages to any participant, or the property of any participant, or be subject to any claim, demand, or injury, or damages whatsoever, including, without limitation, those damages or injuries resulting from acts of negligence on the part of the Pilates Center, its owners, employees, or substitutes. In consideration of my acceptance as a participant in such activities, I expressly waive, release, and discharge The Pilates Center of Austin, its owners, officers, employees, substitutes, agents, and successors from any obligations, liabilities, claims, demands, costs, and expenses, including attorney fees, arising out of, or in connection with, any bodily injury or sickness, however caused, occurring during or after my participation in the exercise program. The Pilates Center of Austin shall not be responsible or liable for any articles lost, stolen, or damaged in or about the studio. If signing as a parent/guardian with legal responsibility of a minor, I, for myself, my spouse, and child/ward do consent and agree to the above on his/her behalf and agree to indemnify and hold harmless The Pilates Center of Austin for any and all liabilities incident to my minor child's/ward's presence or participation.

Client Responsibilities

- I agree to provide accurate health information and inform the practitioner of any medical conditions, injuries, or allergies that may affect the therapy.
- I will communicate any discomfort or concerns during the session to the practitioner.
- I understand that I have the right to stop the session at any time if I feel uncomfortable or if the therapy is causing pain.

Confidentiality

All information shared during the therapy sessions will be kept confidential and will not be disclosed to any third parties without my written consent, except as required by law.

Cancellation Policy

I understand that if I need to cancel or reschedule my appointment, I must provide at least 24 hours' notice. Failure to do so may result in a cancellation fee.

Signature

By signing below, I acknowledge that I have read and understood the information provided in this consent form, and I agree to proceed with Myofascial Release therapy (MFR) at the Pilates Center of Austin.

Client's Signature: _____ Date: _____

Practitioner's Signature: _____ Date: _____

Please circle on the body image where you are experiencing pain and would like the practitioner to work on: