



## CONSENT FOR TREATMENT

I do hereby consent to treatment of my condition by the staff of The Pain Management Center. I also certify that no guarantees or assurances have been made to me as to the results that may be obtained as a result of procedures, treatment and/or techniques used by The Pain Management Center. I further understand that while I am being assessed and/or treated at The Pain Management Center will not be held responsible for any injury sustained outside of its immediate physical premises.

\_\_\_\_\_ Date: \_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_ Date: \_\_\_\_\_  
**Alternate Signature** (if patient cannot sign)