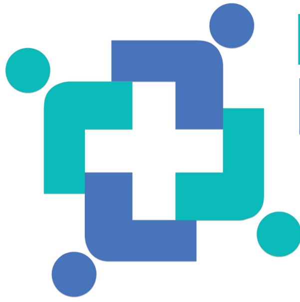

MidMichigan
therapeutic massage care
Improving the quality of living. One person at a time.™

1310 Ashly Court Midland, MI 48640 | Phone: 989-450-0363 | Fax: 989-839-2755
Email: Shannon-Oriedo@mmtmc.org | www.mmtmc.org

WEB TESTIMONIAL

Patient/Client Testimonial Questionnaire Form

Dear esteem client/patient:

Thank you for agreeing to share, through this testimonial, your personal story with others on how MidMichigan Therapeutic Massage Care, LLC is improving the quality of living --one person at a time --in our community by way of effective massage therapy healthcare treatment program that is evidence-based, results-driven, and individually focused.

As an esteem client/patient, your testimonial reflects a bona fide personalized experience with our program; therefore, your account offers a unique perspective on how our massage therapy healthcare program has benefited you personally; and how others in our community can also benefit accordingly.

Please note that *client/patient testimonials* are important component of MidMichigan Therapeutic Massage Care *community outreach* program. A program structured to educate and empower those in our communities we serve with the furtherance of their specific massage therapy healthcare needs, and attainment of optimal and sustainable healthy living and overall health wellness. Accordingly, the integrity of each testimonial is utmost; and as such, the authenticity of each testimonial is vital. Consequently, there is need to authenticate each testimonial by use of real full names (and where applicable, company name and logo), and pictures (taken by us and approved by you, the client/patient) of clients/patients who provide testimonials. Thus, we urge you to consent to the use of your full name and a photograph in the testimonial.

MidMichigan Therapeutic Massage Care, LLC will not provide any protected information to the media or public; this includes your private health information in our medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

Thankfully yours,

Shannon L. Oriedo, CMT
Managing Director & Massage Therapy Specialist

Last Name	Initial	First Name

Profession or Job Title

Company Name (if applicable)

Address

City	State	Zip Code

1. What was/is your main reason (health/medical condition) for seeking our massage therapy treatment program/ services?

2. Was the above stated condition diagnosed by a qualified healthcare practitioner? *Please explain.*

3. What other treatments and/or remedies had/have you received before coming to MidMichigan Therapeutic Massage Care?

4. How effective were these other treatments and/or remedies you received prior to coming to MidMichigan Therapeutic Massage Care?

5. What was your reason for selecting MidMichigan Therapeutic Massage Care as your massage therapy healthcare provider?

6. Briefly, how has MidMichigan Therapeutic Massage Care massage therapy treatment program benefitted you? *That is, did we meet or exceed your expectation (goals)? Please explain by stating your primary treatment goal(s) and how we performed versus your personal expectation(s).*

7. Concisely, what's your opinion of the specific massage therapy treatment services you received from us?

8. What's your overall opinion of MidMichigan Therapeutic Massage Care's massage therapy treatment program?

9. Would you use MidMichigan Therapeutic Massage Care services again, or recommend us to others? *Please explain.*

10. List one or two specific areas you consider as the strength of our massage therapy treatment program/services.

PATIENT/CLIENT TESTIMONIAL RELEASE CONSENT

By signing this form, you are hereby consenting to allow MidMichigan Therapeutic Massage Care, LLC to use and disclose the information in your testimonial and acknowledge that your testimonial may be distributed to the public.

You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to the Contact Person listed above. Please understand that revocation of this Release will not affect any action MidMichigan Therapeutic Massage Care, LLC took in reliance on this Release before receiving your revocation.

CONSENT TO RELEASE

I hereby authorize MidMichigan Therapeutic Massage Care, LLC and its agents to use my testimonial and any information contained herein in its public relations efforts. I understand and approve the disclosure of testimonial information to the media and other individuals and entities that may be involved in the public relations efforts of MidMichigan Therapeutic Massage Care, LLC.

I understand that I am providing the testimonial information to MidMichigan Therapeutic Massage Care, LLC and/or its agents. I also understand that MidMichigan Therapeutic Massage Care and/or its agents will not be providing any protected information to the media or the public, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release MidMichigan Therapeutic Massage Care, LLC and/or its agents from any and all claims for damages of any kind based on the use of my testimonial or information in the testimonial. By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Consent to Release my Patient Testimonial.

Do you consent to MidMichigan Therapeutic Massage Care using your name with this testimonial?	◯ YES	◯ NO
Do you consent to MidMichigan Therapeutic Massage Care using your photo with this testimonial?	◯ YES	◯ NO

Signature ______________________________ Date ____________

Name: ______________________________

Address ______________________________

City ____________ State ____________ Zip Code ____________

Email Address: ____________ Phone Number ____________