Consent Form

PATIENT CONSENT: By answering the following questions, you will assist our team in identifying if you are a qualified to receive the application of today's treatment.

Are you pregnant?	Yes ☐	No ☐
Do you have cancer/tumor?	Yes ☐	No ☐
Do you have a skin infection?	Yes ☐	No ☐
Are 16-years of age or younger?	Yes ☐	No ☐
Do you have a tear in the tendon?	Yes ☐	No ☐
Do you have a cardiac pacemaker?	Yes ☐	No ☐
Do you have bleeding disorder/tendency to bleed?	Yes ☐	No ☐
Are you on NSAIDS, OPIOIDS or anti-coagulant treatment?	Yes ☐	No ☐
Have you received a cortisone injection within the last 30-days?	Yes ☐	No ☐

Please list which areas of concern you would like addressed and treated.

_____

_____

RISKS OF PROCEDURE: There may be temporary pain &/or soreness.
This typically resolves within hours or 1-2 days.

I, _____ , (circle one: Patient / Legal Guardian) do hereby consent to authorize the application of today's treatment for the above stated issues. I fully understand the nature of today's treatment/procedure. I have researched the treatment option &/or the treatment has been fully explained to me by the treating physician/staff. I confirm that upon entering the facility I have been provided the opportunity to have a discussion to clarify any concerns I may have. I authorize that guaranteed results/expectations have not been promised to me. I also understand I am forgoing the opportunity for alternative &/or medical treatments and opting to have today's treatment per my personal discretion.

Signature: _____ **Date:** _____