Shockwave Therapy Patient Consent Form

First Name **Last Name** **DOB:**

Suitability for ESWT (Extracorporeal Shockwave Therapy), also known as Softwave Tissue Regeneration Technologies.
By answering the following questions, you will assist us to decide if you are suitable for ESWT.

Have you been injected with cortisone this month?
◯ Yes ◯ No

Are you using a cardiac pacemaker?
◯ Yes ◯ No

Do you have cancer/tumor?
◯ Yes ◯ No

Do you have a skin infection?
◯ Yes ◯ No

Are you pregnant or do you suspect you may be pregnant?
◯ Yes ◯ No

Are you under 16 years of age?
◯ Yes ◯ No

RISK OF THIS PROCEDURE:

A) Pain and Soreness. This is temporary and resolves after a few days.

B) The FDA has labeled this a "Non-Significant Risk" therapy

Consent for Procedure:

I, do hereby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT).

Signature

I authorize Symmetry Chiropractic & Acupuncture to use and disclose for educational and/or marketing purposes my first name, photographic and/or video images of me, and/or testimonials that I have provided regarding the practice.

Choose One:
◯ Yes ◯ No

Signature

Minor's Guardian's Consent:

- **In addition, the fee for the initial Discovery Visit is $49.**

I have been fully informed of ESWT which the use of has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirm that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me mostly for pain relief and may offer an improvement of function. I also understand foregoing treatment is not the first option for my condition and an alternate treatment has either already been provided or offered to me.

Signature
