FLOWER MOUND

PATIENT INFORMED CONSENT

RADIAL SHOCKWAVE THERAPY TREATMENT

I hereby authorize________________________________ to use Radial Shockwave Therapy for the treatment of chronic soft tissue tendinopathy by causing an inflammatory response/micro trauma to the affected targeted tissue and increasing localized blood circulation. It may take up to 5 treatments to obtain optimal results. Although these devices are highly effective (up to 80%) in most cases, no guarantees can be made.

The procedure may result in the following adverse experiences or risks:

- DISCOMFORT – Some discomfort may be experienced during treatment. Some patients with acute indications may have sensitivity post-treatment.
- SWELLING, HEMATOMAS
- BRUISING/REDNESS – Bruising and/or Redness of the treated area may occur.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR THE ENPULS TREATMENT, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

________________________	________________________	________________
Signature-Patient or Guardian	**Print Name/Relationship**	**Date**
________________________	________________________	________________
Signature-Witness	**Print Name**	**Date**