SoftWave Therapy Consent Form

Name: _____ DOB: _____

Address: _____ City, State, Zip: _____

Phone: _____ Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Suitability for Therapy

Please answer the following questions to determine your suitability for SoftWave Therapy.

- Do you have a cardiac pacemaker?* ☐ Yes ☐ No
- Do you have any active cancers or tumors?* ☐ Yes ☐ No
- Are you pregnant or suspect you may be pregnant?* ☐ Yes ☐ No
- Have you been injected with cortisone in the last 21 days? ☐ Yes ☐ No
- Do you have any known blood disorders? ☐ Yes ☐ No
- Are you currently taking any blood-thinning medication? ☐ Yes ☐ No
- Do you have a history of tinnitus or ringing in the ears? ☐ Yes ☐ No
- Are you 18 years of age or under? ☐ Yes ☐ No

POSSIBLE SIDE EFFECTS

SoftWave Therapy is considered a "Non-Significant Risk" therapy by the FDA for cleared indications. While uncommon, possible side effects include:

- Mild to moderate pain and soreness in the treatment area, typically resolving within a few days.
  If you experience any unexpected side effects or worsening symptoms, please contact your healthcare provider immediately.

CONSENT FOR PROCEDURE

I, _____, consent to SoftWave Therapy for addressing the area(s) of:

_____.

I have been informed about SoftWave Therapy including its purpose, benefits, potential outcomes, and risks, as explained by my provider or a trained staff member. I understand that no guarantees have been made regarding pain relief or improved function.

I acknowledge that I have had the opportunity to ask questions about the procedure and its alternatives, and I agree to proceed with SoftWave Therapy.

Signed _____ Date: _____