**Consent to Treat Form**

**Patient Information**

* **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_

**1. Consent to Treatment**

I voluntarily consent to receive Extracorporeal Shock Wave Therapy (ESWT) for the treatment and management of my musculoskeletal condition. I understand that ESWT is a non-invasive procedure that has been extensively studied for its positive therapeutic effects.

**2. Acknowledgment of Payment Policy**

I acknowledge and understand that:

* **Insurance Coverage:** Insurance companies consider ESWT a "non-covered expense" and do not reimburse for its use.
* **Financial Responsibility:** I am responsible for all costs associated with ESWT treatments as outlined below, due at the time of service:

**3. Potential Risks and Benefits**

I have been informed about the potential risks and benefits associated with ESWT, including but not limited to:

* **Benefits:** Relief of pain, improved mobility, and accelerated healing of musculoskeletal disorders.
* **Risks:** Mild discomfort during treatment, temporary redness or swelling, and rare instances of bruising.

**4. Alternative Treatments**

I understand that alternative treatments are available, and I have had the opportunity to discuss these options with my healthcare provider.

**5. Confidentiality**

I acknowledge that all personal and medical information will be kept confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

**6. Right to Refuse or Withdraw Consent**

I understand that I have the right to refuse or discontinue treatment at any time without prejudice to future care.

**7. Questions and Understanding**

I have had the opportunity to ask questions regarding the treatment and this consent form. All questions have been answered to my satisfaction.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_