PATIENT ACKNOWLEDGEMENT FORM

OrthoWave DualSync™ · Cellular Healing Technologies

theorthowave.com
(770) 746-3322

This form confirms that you have been informed about OrthoWave™ shockwave therapy, its benefits, possible risks, contraindications, and expected outcomes. **Please read carefully and ask your provider any questions before signing.**

PATIENT INFORMATION

Patient Name:		**Date of Birth:**	
Phone Number:		**Email Address:**	
Treatment Date:		**Provider Name:**	
Condition Being Treated:		**Referring Physician:**	

PATIENT ACKNOWLEDGEMENTS

I understand and acknowledge the following regarding OrthoWave™ shockwave therapy treatment:

☐	**Non-Invasive Treatment**	OrthoWave™ shockwave therapy is a non-invasive treatment intended to assist with pain reduction, tissue healing, and cellular regeneration.
☐	**No Guaranteed Outcomes**	Results may vary from patient to patient and no guarantees have been made regarding outcomes. Individual results depend on condition, chronicity, and patient response.
☐	**Multiple Sessions Required**	Multiple treatment sessions are typically required for optimal results. A full course of treatment (5–8 sessions) is recommended before assessing final outcomes.
☐	**Expected Side Effects**	Temporary soreness, redness, bruising, swelling, or discomfort may occur after treatment. These effects are normal, expected, and typically resolve within 24–72 hours.
☐	**Full Medical Disclosure**	I have disclosed all known medical conditions, current medications, implants, recent surgeries, and recent procedures to my provider prior to treatment.
☐	**Contraindication Awareness**	I understand there are certain contraindications including pregnancy, active cancer, blood clotting disorders, active infections, pacemakers, and acute fractures that may prevent treatment.
☐	**Reporting Unusual Symptoms**	I understand I should notify my provider immediately if I experience unusual pain, symptoms, or adverse reactions during or after treatment.
☐	**Electronic Device Distance**	I understand that electronic devices including phones, tablets, and wearables should remain at least 3 feet away from the treatment area during treatment.
☐	**Post-Treatment Instructions**	I agree to follow all post-treatment instructions provided by my OrthoWave provider, including activity restrictions and hydration recommendations.
☐	**Consent to Treatment**	I voluntarily consent to receiving OrthoWave™ DualSync™ shockwave therapy treatment and understand I may withdraw my consent at any time.

PATIENT CONSENT & SIGNATURE

By signing below, I confirm that I have read and understood all of the above acknowledgements, that my questions have been answered to my satisfaction, and that I voluntarily consent to receiving OrthoWave™ DualSync™ shockwave therapy treatment.

Patient Signature

Signature

Date: _____

Provider / Clinician Signature

Signature

Date: _____

Professional Clinical Use Only: This acknowledgement form should be reviewed with the patient prior to treatment and signed before the first session begins. Retain the original signed copy in the patient's medical record. Provide the patient with a copy upon request. Contact OrthoWave at **(770) 746-3322** or **theorthowave.com** for clinical support.