

Extracorporeal Pulse Activation Technology (EPAT®) Patient Declaration of Consent Form

Patient Information:

First Name/Last Name: _____

Date of Birth: _____

During a patient meeting held on _____ (date) to discuss the upcoming EPAT procedure, the clinic's treatment provider, Dr. _____ informed me that the _____ (area) will be treated using EPAT acoustic pressure waves.

I agree to complete the recommended series of treatments in order to maximize my clinical outcome.

I declare that I have read and understood the patient information, the entire contents of the declaration of consent and that I have received a copy of the declaration.

I consent to the procedure and to the tracking of my treatment/outcome data.

Patient's Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____