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## Consent to Treat

Date: \_\_\_\_\_

I, \_\_\_\_\_, ("Patient") hereby authorize Dr. Jeffrey P. Haggquist and/or any of the Therapists working in his clinic and under his supervision to treat with the therapeutic modalities prescribed by Dr. Jeffrey P. Haggquist. Such therapeutic modalities may include (but are not limited to) Active Isolated Stretching ("AIS"), Active Isolated Strengthening, Neuromuscular Therapy ("NMT"), massage, ice massage, Deep Muscle Stimulation, and therapeutic exercise (collectively the "Therapeutic Modalities").

Possible risks associated with Therapeutic Modalities may include:

**Temporary: Dizziness**  
**Nausea**  
**Joint inflammation**

**Muscle / soft tissue tearing (if taking cholesterol reducing medication such as Lipitor or Zetia)**  
**Muscle soreness**

I am aware that there are certain risks associated with this treatment, and that the practice of medicine is not an exact science. I acknowledge that there are no guarantees concerning the results of the treatment or its interpretation. By signing below, I certify that I have read and understand the contents of this form.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Witness

### IF THE PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING:

It is acknowledged that Patient is a minor, \_\_\_\_\_ years of age, or is otherwise unable to consent, therefore, the undersigned, acting as the Patient's authorized representative, hereby consents to the treatment as described above.

Signature of authorized representative: \_\_\_\_\_