

CONFIDENTIAL

CLIENT/PATIENT INTAKE PACKET

10/18

Today's Date: _____ Name: _____ Date of birth: _____ Age: _____

Street address: _____ City: _____ Zip: _____

Mobile phone: _____ Work phone: _____ Home phone: _____

Email: _____ SSN: _____ Marital status: _____

How did you hear about the Fitness Lab? _____

EMPLOYER

Employer name: _____ Occupation: _____

Street address: _____ City: _____ Zip: _____

Years employed: _____

INSURANCE

Name of policy holder: _____ Date of birth: _____ SSN: _____

Name of beneficiary if different than policy holder: _____ Date of birth: _____ SSN: _____

Member ID#: _____ Group ID#: _____ Phone: _____

Address: _____ Fax: _____

MOTOR VEHICLE / WORKERS COMP CLAIM

Employer / Insurance: _____ Adjuster: _____

Claim number: _____ Group ID#: _____ Fax: _____

Address: _____

EMERGENCY CONTACT

Emergency contact name: _____ Relationship: _____

Street address: _____ City: _____ Zip: _____

Mobile phone: _____ Work phone: _____ Home phone: _____

MEDICAL DOCTOR

Referring doctor name: _____ Practice or clinic name: _____

Phone: _____ Fax: _____

Address: _____

OTHER/SPECIALIST

Other doctor or specialist name: _____ Practice or clinic name: _____

Phone: _____ Fax: _____

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MEDICAL HISTORY

10/18

Today's Date: _____ Name: _____ Date of birth: _____ Age: _____

Occupation, including activities that comprise your workday: _____

Leisure activities, including exercise routines: _____

Are you on a work restriction from your doctor? Yes No Do you have a pacemaker? Yes No Do you smoke? Yes No

WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

List any allergies you are aware of (including latex): _____

How would you describe your diet? _____

Have you recently noted any of the following? (check all that apply):

- | | | | |
|--------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> difficulty with balance /
of falls _____ | <input type="checkbox"/> dizziness / lightheadedness / fainting | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> fever / chills / sweats | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> heartburn / indigestion | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> nausea / vomiting | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> cough |
| <input type="checkbox"/> weight loss / gain | | <input type="checkbox"/> headaches | |

Have you EVER been diagnosed with any of the following conditions? (check all that apply):

- | | | | |
|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> cancer | <input type="checkbox"/> sexually transmitted disease / HIV | <input type="checkbox"/> bladder / urinary tract infection | <input type="checkbox"/> depression |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> pneumonia | <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> lung problems | <input type="checkbox"/> thyroid problems <input type="checkbox"/> hypo <input type="checkbox"/> hyper | <input type="checkbox"/> Alzheimers / dementia |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> diabetes | <input type="checkbox"/> neurological condition |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> asthma | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> blood clots / bleeding disorder | <input type="checkbox"/> arthritis (rheumatoid or osteo) | <input type="checkbox"/> epilepsy / seizures | <input type="checkbox"/> stomach problems |
| <input type="checkbox"/> stroke / TIA | <input type="checkbox"/> autoimmune disorder | <input type="checkbox"/> ulcers | <input type="checkbox"/> low pain tolerance |
| <input type="checkbox"/> anemia | <input type="checkbox"/> spine problem | <input type="checkbox"/> liver problems | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> recent infection | <input type="checkbox"/> osteoporosis / osteopenia | <input type="checkbox"/> eating disorder | _____ |
| <input type="checkbox"/> eye problem / visual disturbance | <input type="checkbox"/> fractures | <input type="checkbox"/> ulcers | |
| <input type="checkbox"/> chemical dependency
(alcoholism <input type="checkbox"/> drug <input type="checkbox"/>) | <input type="checkbox"/> gout | <input type="checkbox"/> neurological problems | |
| | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> eating disorder | |

During the last month, have you been feeling down, depressed, or hopeless, or decreased interest or pleasure in doing things? Yes No

Is this something with which you would like help? Yes Yes, but not today No

Current medications (including pills, supplements, injections, and/or skin patches): _____

Have you ever taken steroid, blood thinning, or anticoagulant medications for any medical conditions? Yes (when?) _____ No

Please list special tests performed for current condition (x-ray, MRI, labs, etc.): _____

Please list all surgeries and/ or other conditions for which you have been hospitalized, including dates: _____

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CURRENT SYMPTOMS/COMPLAINT

10/18

Today's Date: _____ Name: _____ Date of birth: _____ Age: _____

Primary complaint: _____

What date (approximately) did your present symptoms start? _____

What do you think caused your symptoms? _____

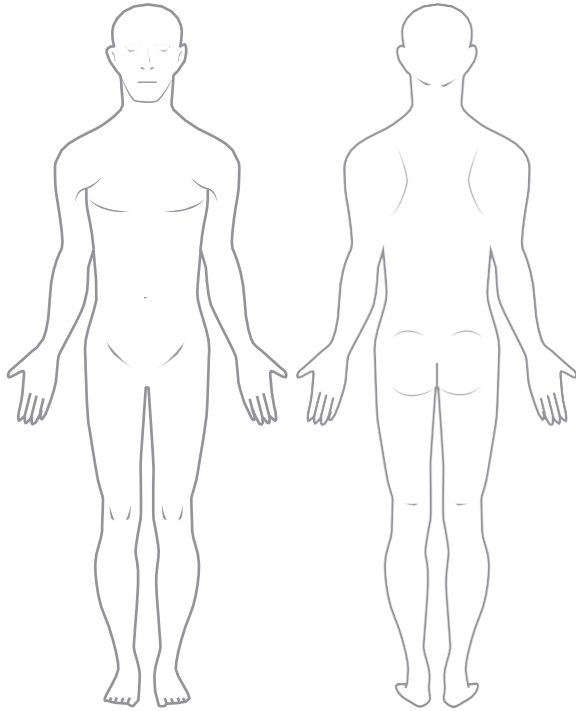
Treatment received so far (chiropractic, injections, etc.): _____

Have you ever had this problem before? Provide dates and any treatment received: _____

How long did it take for you to feel better? _____

Please mark the areas where you feel symptoms: **X = PAIN** // = **NUMBNESS OR TINGLING** (Please fill out diagram later if filling electronically)

How would you describe your symptoms? _____



My symptoms currently: come and go are constant are constant, but change with activity

Using the 0-10 scale, with "0" being no pain and "10" being the worst pain imaginable, please circle:

Average for the past week: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

Worst for the last week: 0 1 2 3 4 5 6 7 8 9 10

Aggravating factors: Identify positions or activities that make your symptoms **worse**:

1. _____

2. _____

3. _____

Easing factors: Identify positions or activities that make your symptoms **better**:

1. _____

2. _____

3. _____

Are you able to sleep at night due to your symptoms? No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

If awakened by pain, how long does it take to fall back to sleep? _____

What is your sleep position? Back Side Stomach

When are your symptoms the **worst**? Morning Afternoon Evening Night After exercise

When are your symptoms the **best**? Morning Afternoon Evening Night After exercise

What goals do you hope to achieve with training and physical therapy? _____

Signature: _____ **Date:** _____

TFL Provider Network LLC
Consent Form | Financial Agreement | Privacy Practices

Thank you for choosing TFL Provider Network LLC, d/b/a The Fitness Lab, for your rehabilitation. We are committed to providing the highest quality physical therapy and personal training services. Our office has adopted the following Consents and Financial Policies. We require that each Client/Patient read and agree to this Policy form prior to beginning and/or continuing their treatment. If the Client/Patient is a minor, we require a co-signature of a Parent or Guardian.

Insurance

Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. We will file claims to your insurance company. All health plans are not the same and they do not always cover the same services. In the event that your health plan determines that a service is “not covered” you will be responsible for the entire charge or a previously agreed upon rate. Our office is not responsible for disputing decisions made by your insurance carrier regarding coverage.

Although we provide an estimate of benefits as a courtesy to all patients, we expect you to familiarize yourself with the benefits and limitations of your insurance policy including your deductible, coinsurance and co-payment amounts. Estimated patient responsibility will be provided prior to treatment, when available, and is subject to change at any time. It is the patient's ultimate responsibility to notify our office when either their insurance plan or benefits change.

Deductibles/Co-payments/Payments

Our insurance contracts require us to collect deductibles, coinsurance and copays. Patient responsibility amounts will be collected at each visit prior to service being rendered. For your convenience we accept Visa, MasterCard, Discover and American Express in addition to personal checks and cash. If your check is returned or your credit card declines due to insufficient funds, we have the right to assess a service charge of \$50 for each occurrence. When you provide a check as payment, you authorize us to use information from your check to make a one-time electronic fund transfer from your account.

Financial Agreement

Self-Pay: I understand that payment will be made at the time the services are rendered.

Private Health Insurance/Medicare: We collect on copays, deductible amounts and co-insurance at the time services are rendered. If there is a remaining balance a statement will be mailed to me each month showing the total balance due from me and will be considered past due within 30 days from receipt. If I am unable to make a payment, I understand that I should call the billing department immediately at 303-800-2829 to make payment arrangements. I understand that if no payment has been received after 45 days, my account may be referred for collections. If my account is referred to collections, I understand that I will be responsible for the balance as well as all collection costs and reasonable attorney’s fees.

Workman’s Compensation/MVA: If my therapy is a work-related injury and has been approved by my employer or employer’s representative as a work injury, I understand that my employer, work comp carrier or MedPay through MVA Insurance carriers will be financially responsible for payment of my treatment.

Personal Training/MedEx: All sales are final, no refunds. Visits will be applied as credits to your account. Packages have set expirations based upon the number of visits purchased.

Consent for Treatment

While I am here, I permit the clinicians to treat me in ways they judge are beneficial to me. I understand that the clinician will explain to me the nature of my condition and their recommended treatment.

Assignment of Benefits

I hereby authorize TFL Provider Network LLC to release all information necessary to my private health insurance, Medicare or workman’s compensation carrier for reimbursement for services provided. I agree to provide such information as needed to establish my eligibility for such benefits. This statement will remain in effect until revoked by me in writing.

Acknowledgment and Understanding

I, the undersigned, acknowledge that I have read, understood, and agree to comply with the policies outlined in this document. I affirm that I have had the opportunity to ask questions for clarification and that my signature below serves as confirmation of my understanding and acceptance of these policies.

Print Name

Signature of Client/Patient

Date

Waiver, Release and Assumption of Risk Agreement

In consideration of permission to use the facilities, equipment, services, premises, and products provided at TFL Provider Network LLC, d/b/a The Fitness LAB (hereafter the "Company") today, and at any time in the future.

I understand and agree to all the following:

Assumption of Risk: I understand that any physical activity carries with it an inherent risk of injury. Physical therapy and training can involve strenuous exertions of various muscles placing stress on the muscles, bones, and joints. Cardiovascular training can involve sustained physical activity placing stress on the heart, arteries, and blood pressure. Risk of injury may be minor such as soreness, sprains, strains, and bruises, or serious such as heart attack, stroke, paralysis, and death. I understand these risks and agree to assume all risk of injury, illness or death associated with exercise whatever the cause.

Indemnification and Hold Harmless: I agree to protect and hold the Company, its managers, employees, agents, contractors, and representatives harmless from any claims, costs, damages, or legal fees resulting from my negligence, wrongful actions, or breach of this agreement. This includes covering expenses related to any investigation, arbitration, or lawsuit arising from my actions.

Interpretation: This Agreement is intended to be interpreted as broad and as inclusive as permitted by the laws of Colorado to relieve the Company and all others associated in any way with the Company, from all liability for any and all claims for damages due to injury or property loss based on any legal theory. This Agreement shall be interpreted under the laws of Colorado.

Severability and Venue: If any portion of this Agreement is held invalid, the balance of the Agreement shall continue in full legal force. The parties agree to the exclusive jurisdiction and venue of the state courts located in Douglas County, Colorado.

Consent to physical contact: It is sometimes necessary for a physical therapist or a trainer to physically touch a client to attain the proper form for an exercise or perform certain manual techniques as allowed by law. I hereby consent to such appropriate physical contact.

Consent to Public Presence: I understand and acknowledge that during the course of my physical therapy treatment members of the public may be present for personal training, to observe personal training or to inquire about the services being provided by the Company and that I agree to the presence of members of the public

being present in the Company's premises while I am receiving physical therapy treatment(s).

Liability Release: In consideration of permission to use, today and on all future dates, the property, facilities, and services of the Company and to participate in weight training, cardiovascular training, physical therapy and rehab, and other physical activities, I, on behalf of myself, my heirs, personal representatives, agents and assigns, do hereby, release, waive, and discharge the Company, and any of its employees, volunteers, independent contractors, officers, managers and agents (collectively, the "Released Parties") from liability from any and all claims arising from my own negligence, the negligence of others, or the negligence of the Released Parties, as well as my breach of any agreement between the parties.. This Agreement applies, but is not limited to: 1) personal injury (including death) from accidents or illnesses arising from the participation in physical activities including, but not limited to, organized activities, classes, observation, physical therapy, rehabilitation therapy and individual use of facilities, premises, or equipment; and 2) any and all claims resulting from the damage to, loss of, or theft of property. I certify that I know of no medical problem (except those noted herein) that would increase my risk of illness and injury because of participating in a physical training program, independently working out at the Company's facilities, or otherwise availing myself of the use of the Company's premises. I understand that I have been advised to consult a physician prior to commencement of a physical training program to ensure my state of wellness to participate in such strenuous activities. I further agree to indemnify and hold the Released Parties harmless for any loss, damage, claim or cause of action and further to defend any such claims or causes of action brought by any third-party resulting from my actions or caused by me for which the Released Parties are sought to be held or are held responsible or liable including attorney's fees and arbitration costs.

I have read the entire Waiver, Release and Assumption of Risk Agreement. I have not relied on any oral representations by anyone in addition to, or inconsistent with, the written terms of this Agreement. I accept the conditions stated herein as a requirement to participate in this program. I understand and intend that this document will act as the broadest and most inclusive assumption of risk, waiver, release of liability and indemnification as is permitted under the laws of Colorado. I am signing this Agreement as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, agents, and assigns. I agree to the terms of this Waiver, Release and Assumption of Risk Agreement.

Print Name

Signature of Client/Patient

Date

EMR ID: _____

Patient DOB: _____

Privacy Practice Acknowledgement

I have received TFL Provider Network, LLC’s Notice of Privacy Practices and I have been provided with an opportunity to review it. I understand that if my care is due to a work-related injury, my records will be released to the case manager, worker’s compensation insurance carrier, employer at the time of injury and referring doctor. If this is not work related, my records will only be released to my own insurance company and the referring doctor. Any other persons’ you wish for us to release information to must be requested by you in writing on an approved form. Additional comments/restrictions on the use and disclosure of my protected health information:

You must choose one of the following:

- I give consent to release and/or leave a message regarding appointments, treatment or other information as necessary on the answering machine at home, voicemail on cell phone or at work.
- I give consent to speak with the following person/s regarding my treatment:

Name: _____ Relationship: _____ Number: () _____ - _____

Name: _____ Relationship: _____ Number: () _____ - _____

- I do not consent to messages containing protected information being left. Please contact me directly at () _____ - _____ or () _____ - _____.

Cancellation/No-Show Policy

Attending your scheduled visits is crucial to your rehabilitation. We ask that you please be respectful of this policy and provide enough notice so that we can offer appointment times to other patients on our waitlist.

Our policy at TFL Provider Network LLC is that in the event of a late cancellation or no-show, **regardless of the circumstances**, the following will occur:

- Your case manager, adjustor and physician will be notified via phone and/or fax (for Workers Compensation and MVA Only)
- We require that you provide at least **24 hours' notice** if you need to cancel or reschedule your appointment. Cancellations made with less than 24 hours' notice are subject to a **\$75 cancellation fee**.
- Cancellations made over weekends or holidays are considered late cancellations and are subject to a **\$75 cancellation fee**.
- If you are greater than 15 minutes late, it will be at the treating therapist’s discretion whether or not you will be treated or rescheduled.
- You will incur a \$75 charge if unable to **reschedule within the same business week**.
- For patients with Medicaid, Medicare or VA insurance, please note the specific cancellation and no-show policy agreement: **A total of 3 late cancels/no-shows will result in discharge from physical therapy.**

Acknowledgment and Understanding

I, the undersigned, acknowledge that I have read, understood, and agree to comply with the policies outlined in this document. I affirm that I have had the opportunity to ask questions for clarification and that my signature below serves as confirmation of my understanding and acceptance of these policies.

Print Name

Signature of Client/Patient

Date

TRIGGER POINT DRY NEEDLING/FUNCTIONAL DRY NEEDLING (TPDN/FDN) CONSENT**What is TPDN/FDN?**

TPDN/FDN is a manual therapy technique using a sterile filament needle to help treat musculoskeletal pain and soft tissue dysfunction. TPDN/FDN also helps to maximize performance by improving flexibility and muscle strength while decreasing symptoms.

How TPDN/FDN works:

Proper nerve functional is needed for a healthy muscle. When the chemical relationship between nerve and muscle are compromised by injury or chronic stress, musculoskeletal pain, decreased flexibility, and weakness occur. TPDN/FDN involves the insertion of very small needle into the area of a trigger point (tender, taught bands of muscle tissue). This allows for release of the trigger point and helps to restore mechanical and chemical balance in the muscle. Although the needles are like acupuncture, TPDN/FDN is a completely different and unique technique requiring advanced continuing education and does not involve distal or auricular point stimulation.

What to expect before, during, and after an TPDN/FDN treatment:

Slight to no pain is felt during needle insertion into a normal muscle supplied by a healthy nerve. However, when the needle is inserted into a trigger point you may experience some pain, cramping, muscle contraction, and/or twitching. TPDN/FDN takes just a few minutes to perform and may include the use of electrical stimulation. Afterward sensations range between achiness and immediate relief of pain. Patients will generally be able to see immediate improvements in flexibility and range of motion followed by decreased pain and improved muscle performance over the next few days to weeks.

Risks and Contraindications:

TPDN/FDN isn't recommended for patients who have an infection, are pregnant, have had recent surgery, or have blood disorders. Please inform your therapist if you are taking any medications (blood thinners etc.). There are certain inherent risks with TPDN/FDN, as it is a uses a needle. Although complications are rare in the hands of a highly skilled therapist, they can occur. The most severe complication associated with TPDN/FDN is a pneumothorax (lung puncture). Should a pneumothorax occur, it would likely require a chest x-ray and may not require further intervention as it can resolve on its own if it is small. Larger pneumothorax could require hospitalization and reinflation of the lung. Symptoms of a pneumothorax are shortness of breath and pain. If you think you have a pneumothorax, please contact your therapist promptly. If it is suspected that you have a pneumothorax, please seek appropriate medical attention from your MD and/ or nearest emergency department. Other possible risks include but are not limited to bruising, soreness, nerve injury, and infection. Bruising and general soreness are normal following needling and usually last between a few hours and a few days. Infection risks are reduced using proper skin care techniques and a sterile, single use, individually wrapped needle.

I have read the entire **Trigger Point Dry Needling/Functional Dry Needling (TPDN/FDN) Consent Agreement** and I understand the associated benefits and risks. I have not relied on any oral representations by anyone in addition to, or inconsistent with, the written terms of this Agreement. I accept the conditions stated herein treatment as a requirement to participate in this treatment. I understand and intend that this document will act as the broadest and most inclusive assumption of risk, waiver, release of liability and indemnification as is permitted under the laws of Colorado. I am signing this Consent as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I agree to the terms of the Trigger Point Dry Needling/ Functional Dry Needling (TPDN/FDN) consent and I am agreeable to treatment with TPDN/FDN.

 Print Name

 Signature of Client/Patient

 Date

INSTRUMENT ASSISTED SOFT TISSUE MOBILIZATION (IASTM) CONSENT

What is IASTM?

IASTM is a manual therapy technique in which a specially trained clinician uses ergonomically designed tools to locate and treat soft tissue dysfunction and musculoskeletal injuries such as fascial restrictions, adhesions, inflammation, and scar tissue. IASTM has been shown to successively increase range of motion, breakdown scar tissue, promote blood flow, improve flexibility, motor control (muscle activation/coordination), and strength while decreasing pain following treatment.

How IASTM works:

When tissue is injured, fibrotic scar tissue and adhesions can form during the healing process which can limit range of motion and flexibility causing pain and ultimately leading to decreased strength and performance. Scar tissue and adhesions are composed of mainly of improperly aligning collagen fibers that act as glue that irregularly binds different layers of tissues together. To properly restore motion and flexibility, it is essential that these irregular bonds between tissues layers are broken down. IASTM introduces precise friction causing a controlled inflammatory process (microtrauma). This microtrauma allows the body to begin the reabsorption of the fibrotic tissue while encouraging proper tissue remodeling throughout the healing process. IASTM followed by the proper stretching and exercises protocol will then promote normal scar tissue remodeling, proper tissue proliferation, and improve overall tissue healing allowing for correct functional movement patterns while decreasing pain.

What to expect before, during, and after an IASTM

Treatment:

Before beginning an IASTM treatment, you will begin with a warm-up as symptoms warrant (active vs. passive). After the warm-up, the clinician will perform IASTM. Following IASTM, the clinician may perform other manual therapy techniques after which you will typically perform a series of flexibility and/or strength activities before being assigned a home exercise program. If applicable, treatment may end with modalities to further decrease any possible discomfort. After treatment, it is normal to experience some soreness for 24 to 48 hours. Although not desired, mild petechiae and bruising may occur during the procedure and should also resolve within a short duration.

Risks and Contraindications:

There are minimal risks associated with IASTM with the greatest being soreness and bruising. Please let your therapist know if you have any bleeding disorders, unhealed fractures, uncontrolled blood pressure, and/ or an infection. Please inform your therapist if you are taking any medications (blood thinners etc.).

I have read the entire **Instrument Assisted Soft Tissue Mobilization (IASTM) Consent Agreement** and I understand the associated benefits and risks. I have not relied on any oral representations by anyone in addition to, or inconsistent with, the written terms of this Agreement I acknowledge and accept the stated conditions as a requirement for participating in this treatment. I understand and intend that this document will act as the broadest and most inclusive assumption of risk, waiver, release of liability and indemnification as is permitted under the laws of Colorado. I am signing this Consent as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I agree to the terms of the Instrument Assisted Soft Tissue Mobilization (IASTM) Consent Agreement, and I am agreeable to treatment with IASTM.

Print Name

Signature of Client/Patient

Date

THERAPEUTIC CUPPING/ MYOFASCIAL DECOMPRESSION (MFD) CONSENT**What is therapeutic cupping/MFD?**

Therapeutic Cupping/Myofascial Decompression (MFD) is a manual therapy technique in which a specially trained clinician uses ergonomically designed tools (cups) to locate and treat soft tissue dysfunction and musculoskeletal injuries such as fascial restrictions, adhesions, inflammation, and scar tissue. Therapeutic cupping/ MFD has been shown to successively increase range of motion, breakdown scar tissue, promote blood flow, improve flexibility, motor control (muscle activation/coordination), and strength while decreasing pain following treatment.

How therapeutic cupping/MFD works:

When tissue is injured, fibrotic scar tissue and adhesions can form during the healing process which can limit range of motion and flexibility causing pain and ultimately leading to decreased strength and performance. Scar tissue and adhesions are composed of mainly of improperly aligning collagen fibers that act as glue that irregularly binds different layers of tissues together. To properly restore motion and flexibility, it is essential that these irregular bonds between tissues layers are broken down. Therapeutic cupping/MFD introduces precise friction causing a controlled inflammatory process (microtrauma). This microtrauma allows the body to begin the reabsorption of the fibrotic tissue while encouraging proper tissue remodeling throughout the healing process. Therapeutic cupping/ MFD followed by the proper stretching and exercises protocol will then promote normal scar tissue remodeling, proper tissue proliferation, and improve overall tissue healing allowing for correct functional movement patterns while decreasing pain.

What to expect before, during, and after therapeutic cupping/ MFD treatment:

Before beginning therapeutic cupping/MFD treatment, you will begin with a warm-up as symptoms warrant (active vs. passive). After the warm-up, the clinician will perform therapeutic cupping/MFD. Following treatment, the clinician may perform other manual therapy techniques after which you will perform a series of flexibility and/or strength activities before being assigned a home exercise program. If applicable, treatment may end with modalities to further decrease any possible discomfort. After treatment, it is normal to experience some soreness for 24 to 48 hours. Although not desired, mild to moderate petechiae and bruising may occur during the procedure and should also resolve within a short duration.

Risks and Contraindications: There are minimal risks associated with therapeutic cupping/MFD with the greatest being soreness and bruising. Please let your therapist know if you have any bleeding disorders, unhealed fractures, uncontrolled blood pressure, and/ or an infection. Please inform your therapist if you are taking any medications (blood thinners etc.).

I have read the entire **Therapeutic Cupping/ Myofascial Decompression (MFD) Consent Agreement** and I understand the associated benefits and risks. I have not relied on any oral representations by anyone in addition to, or inconsistent with, the written terms of this Agreement. I acknowledge and accept the stated conditions as a requirement for participating in this treatment. I understand and intend that this document will act as the broadest and most inclusive assumption of risk, waiver, release of liability and indemnification as is permitted under the laws of Colorado. I am signing this Consent as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I agree to the terms of the Therapeutic Cupping/Myofascial Decompression (MFD) Consent Agreement, and I am agreeable to treatment with MFD.

 Print Name

 Signature of Client/Patient

 Date