Key Therapeutics, LLC: **PEMF Therapy Screening & Consent Form and Fee**

Patient Name: _____ **DOB:** _____ **Date:** _____

☐ **I acknowledge and agree to an additional fee of $20 for PEMF Therapy provided during a 50-minute treatment session.**

Medical Screening: Please check all that apply.

Implanted Electrical/Medical Devices	Medical Conditions/History	Possible Side Effects
☐ Pacemaker	☐ Pregnant, may be pregnant, or trying to become pregnant	• Mild fatigue
☐ Implantable cardioverter defibrillator (ICD)	☐ Seizure disorder/epilepsy	• Dizziness or lightheadedness
☐ Deep brain stimulator	☐ History of cancer, active cancer, or current cancer treatment	• Headache
☐ Spinal cord stimulator	☐ Recent surgery (within 6 weeks)	• Temporary increase in symptoms
☐ Cochlear implant	☐ Active infection or fever ☐ Multiple sclerosis	• Temporary soreness or discomfort
☐ Implanted medication pump	☐ Organ transplant recipient	• Relaxation or sleepiness
☐ Bone growth stimulator	☐ Severe cardiovascular disease or recent stroke	
☐ Other implanted electrical device including vagus nerve stimulator, implanted drug pump, etc.: _____	☐ Recent concussion (within past 3 months)	
☐ None of the above	☐ None of the above	

Additional Medical Information: _____

Patient Acknowledgment

I understand that:

1. PEMF Therapy is an adjunctive therapeutic and wellness modality that may be used as a complement to my treatment.
2. Individual responses vary, and no guarantees regarding treatment outcomes have been made.
3. I have disclosed all known medical conditions, implanted devices, and relevant medical history.
4. I understand that physician clearance may be recommended or required based on certain medical conditions or medical history.
5. I may discontinue PEMF Therapy at any time.
6. I agree to notify **Key Therapeutics, LLC** immediately if I experience discomfort or adverse symptoms during or following treatment.

Consent for PEMF Therapy

I have had the opportunity to ask questions regarding PEMF Therapy, and my questions have been answered to my satisfaction. I voluntarily consent to receive PEMF Therapy.

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____