Cozy Physical Therapy

Patient Name:_____

MPS Treatment Consent

I hereby consent to treatment with Microcurrent Point Stimulation (MPS) Therapy including such assessments, examinations, and techniques, which may be recommended by a therapist of Cozy Physical Therapy.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that MPS therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. Ii acknowledge that with any treatment there can be risks, and those risks have been explained to me and I assume those risks.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me. I understand that at any time I may withdraw my consent and treatment will be stopped.

Contraindications of MPS Therapy:

- Epilepsy / Seizures (no treatment above the neck)
- Pacemaker
- Pregnancy
- Cancer

Patient Signature: _____Date: _____