APOLLO SPORTS
PERFORMANCE

Consent to Treat Form

Patient Information

Please fill out the following information:

- Name: _____
- Date of Birth: _____
- Address: _____
- City: _____

  State: _____

  ZIP: _____
- Phone Number: _____
- Email: _____
- Emergency Contact Name: _____
- Emergency Contact Phone Number: _____

Consent to Treatment

I, _____ (patient name), hereby consent to the treatment provided by Michael Stevens c/o Apollo Sports Performance, LLC for my musculoskeletal injury/condition. I understand that the treatments may include, but are not limited to:

- Cupping Therapy: The application of cups to create suction on the skin, intended to increase blood flow and promote healing.
- Instrument Augmented Soft Tissue Mobilization (IASTM): The use of specialized tools to mobilize soft tissue and enhance tissue healing.
- Massage Therapy: Manual manipulation of soft tissues to relieve pain, improve circulation, and promote relaxation.
- Dry Needling: Insertion of fine needles into trigger points within muscles to relieve pain and improve function.

Potential Risks and Side Effects

I understand that these treatments, while generally safe, may carry certain risks and side effects, including but not limited to:

- Pain or discomfort during and after the treatment
- Bruising, swelling, or redness at the treatment site
- Temporary soreness or fatigue
- Risk of infection with any procedure that involves skin penetration (e.g., dry needling)

Acknowledgment of Alternatives

I acknowledge that alternative treatments exist and that I have been informed about these alternatives, which may include but are not limited to:

- Physical therapy
- Medications
- Surgery
- Other forms of manual therapy

Cancellation and No-Show Policy

I understand that Apollo Sports Performance requires 24-hour notice for cancellations. Failure to provide such notice may result in a cancellation fee.

Legal Considerations

I understand that the practice of athletic training, including all aforementioned treatments, is governed by state and federal regulations. I confirm that I have provided accurate and complete information regarding my medical history and any conditions that may affect my treatment. I also understand that my treatment information will be kept confidential in accordance with HIPAA regulations.

Consent to Treatment

I have read and fully understand the information provided in this form. I have had the opportunity to ask questions and discuss my treatment plan with my athletic trainer. By signing below, I consent to the treatments outlined above and acknowledge that no guarantees have been made to me regarding the outcome of these treatments.

- Patient Signature: _____
- Date: _____

Consent for Minors (if applicable)

If the patient is a minor, a parent or guardian must provide consent:

I, _____ (parent/guardian name), consent to the above treatment on behalf of _____ (minor's name).

- Parent/Guardian Signature: _____
- Date: _____

Athletic Trainer Information

Michael Stevens
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