Shockwave Therapy Recommendations

Patient Name: _____ Date: _____

Treatment	Treatment Schedule	Investment
Shockwave Therapy Treatments 1 Region 2 Regions 3 Regions 4 Regions	_____ X/Week for _____ Weeks _____ X/Week for _____ Weeks _____ X/Week for _____ Weeks _____ Total Treatments	_____
Soft Tissue Therapy	Cupping _____ Sessions E-Stim _____ Sessions FAKTR Fascial Therapy _____ Sessions	_____
Chiropractic Adjustments	_____ X/Week for _____ Weeks _____ X/Week for _____ Weeks _____ X/Week for _____ Weeks _____ Total Visits	_____
Home Devices	■ _____ ■ _____ ■ _____	_____

$ _____
Total Investment

Monthly Payment 3x _____

Pay in Full Discount 1x _____

Patient Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____