INFORMED CONSENT FOR EPAT (SHOCKWAVE)

I, ______________________________________, hereby apply to have an EPAT procedure carried out. This is an attestation statement for EPAT for Erectile Dysfunction/Peyronie's Disease. The EPAT procedure is an FDA approved treatment, which by FDA rules can be used for any purpose that a licensed physician deems appropriate. I am requesting this procedure be done in lieu of a large incision, large scar, significant down time, increased risks, and complications. It is noted that I have not been guaranteed long-term efficacy of the procedure. I have discussed the risks, benefits, potential complications and expected outcomes of the procedure with Dr. Backenstoes. I understand this is an elective treatment that is not covered by insurance.

Attestation Statement

I, ______________________________________, understand the EPAT procedure is not specifically FDA approved for Erectile Dysfunction/Peyronie's Disease. I understand the risks of this treatment as an off label FDA use. I specifically request the use of the EPAT procedure for the specific purpose of Erectile Dysfunction/Peyronie's Disease.

Patient Signature ______________________________ Date ____________________

Physician Signature ______________________________ Date ____________________

Witness ______________________________ Date ____________________

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