# Laser Patient Information Form

All Patients or Patients' Legal Representative, please complete all selections:

**Patient: (Full Legal Name)**

Name: _____ Date : ____/____/____

**Informed Consent:**

Laser Therapy can be a very helpful treatment for many types of injuries. However, depending on each individual patient, it may not be the best option for you if you have certain conditions. By signing the line below, you are saying that you agree with the following statements.

- I am not pregnant
- I do not have a pacemaker
- I can feel warm/hot temperatures on the area being treated
- I do not have cancer/a tumor in the area being treated
- I not taking photosensitive medication

_____

Patient or Authorized Representative's Signature Date

**Informed Consent, Continued:**

Laser therapy is a therapy that is used for treatment of muscle and joint-related pain. Laser promotes the relaxation of spasm/tension and promotes both increased tissues energy production and vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Adverse effects from Laser Therapy occur from multiple sources, in most cases involving a hypersensitivity to light, preexisting medical condition, thermal effects, excessive pressure from the treatment probe and laser over-stimulation. Laser Therapy can cause serious damage to the eye, therefore it is very important to wear the protective glasses that will be provided at all times during treatment. Although rare, the most common adverse effects from Laser Therapy are:

- Temporary increase in pain during laser application and/or the following day
- Mild bruising
- Temporary dizziness
- Reactions when photosensitizing drugs are used with laser therapy

Pain relief from Laser Therapy may be dramatic and substantial, lasting for hours, day or weeks: however, your specific results may vary and there is no guarantee as to the results of Laser Therapy. Your clinician has been thoroughly trained to identify and minimize risk of any adverse reaction.

By signing below, you are stating that you have read and understand the potential risk associated with Laser Therapy, that you have had all of you questions regarding Laser Therapy answered to your satisfaction and agree to the treatment program outlined by your clinician.

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Patient or Authorized Representative's Signature Date