Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. LightForce therapeutic lasers emit infrared light energy into tissue to provide topical heating for the purpose of elevating tissue temperature for temporary relief of minor muscle and joint pain, muscle spasm, pain and stiffness associated with arthritis and promoting relaxation of the muscle tissue and to temporarily increase local blood circulation. Laser therapy utilizes visible and invisible laser radiation; therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment. You may see immediate results after the first treatment, or depending on the severity of your condition, you may require several treatments before beginning to feel results.

Increased soreness may occur after your first laser session. This may be due to changes in circulation to the involved tissues and/ or the impact on different sensory nerves. This is a normal phenomena in the healing process.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

- ☐ I understand the above and consent to treatment.
- ☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

_____ _____

Patient Signature Date

_____

Print Patient Name

_____ _____

Physician Signature Date

Patient Intake Form

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Laser therapy can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check YES or NO to the questions below

YES ☐ NO ☐ Do you have a pacemaker or any other implanted device?

YES ☐ NO ☐ Are you pregnant?

YES ☐ NO ☐ Do you have cancer?

YES ☐ NO ☐ Are you taking medication that may increase your sensitivity to light?

YES ☐ NO ☐ Have you had a steroid injection in the last 7 days?

_____ _____

Patient Signature Date

_____

Print Patient Name

Notes:

The ultimate decision to recommend treatment lies with your health care provider.
Speak with your health care provider if you have further questions about therapy treatment.