

Informed Consent for Laser Therapy

Laser Therapy is a non-surgical application of laser light. Unlike most other forms of therapy, laser therapy is classified “actinotherapy” in that it results in a chemical and metabolic change of the involved tissues. As a result, laser therapy can relieve pain, decrease inflammation, accelerate the healing of tissue (biostimulation), increase blood flow and decrease tissue swelling.

Like all forms of medical treatment, there are associate risks as well as benefits. Exposure to the eyes during the procedure may result in damage of the retina. Under certain situations a superficial burn of the skin could occur. This is based upon skin pigmentation, skin discolorations (i.e. tattoos), or the use of topical creams, lotions or analgesic balms.

In order to prevent adverse reactions to laser therapy, all patients must adhere to the following guidelines:

- Wear approved safety goggles during all laser treatment session;
- Avoid the use of any topical creams, lotions or analgesic balms before or immediately after treatment;
- Inform the doctor of any skin conditions including skin sensitivity to light;
- Clean the area of treatment thoroughly prior to your scheduled appointment.

By signing below I acknowledge that I wish to proceed with laser therapy which the doctors at Albany Podiatry have deemed to be medically necessary in the care and treatment of my condition.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING KNOWLEDGE, I KNOWINGLY AUTHORIZE CERTIFIED LASER TECHNICIAN TO PROCEED WITH MLS LASER THERAPY AND TREATMENT.

DATED THIS _____ DAY OF _____, 20 ____, Albany, NY

Patient’s Name

Age of Minor

Patient’s Signature OR
Authorized adult of minor

Signature of Doctor

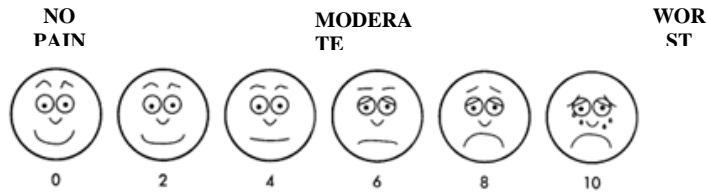


Existing Patient Registration
MLS Laser Therapy



Name
Address
City/State/Zip
Home Phone Cell Phone
E-mail address Date of Birth
Primary complaint

Length of time with this condition
How did you hear about MLS Laser Therapy?



Use this chart to estimate your pain level (Circle One).

Have you ever been diagnosed with cancer? Y/N, explain:
Do you have an implanted neurostimulator device? Y/N, where:
Do you have a pacemaker? Y/N

Please check any of the following that apply to you:

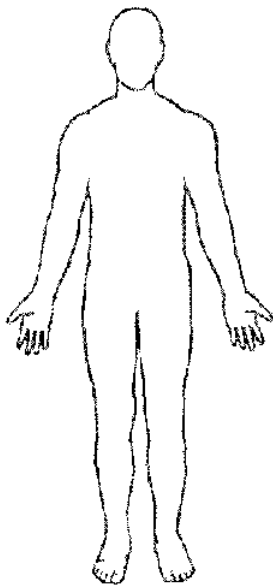
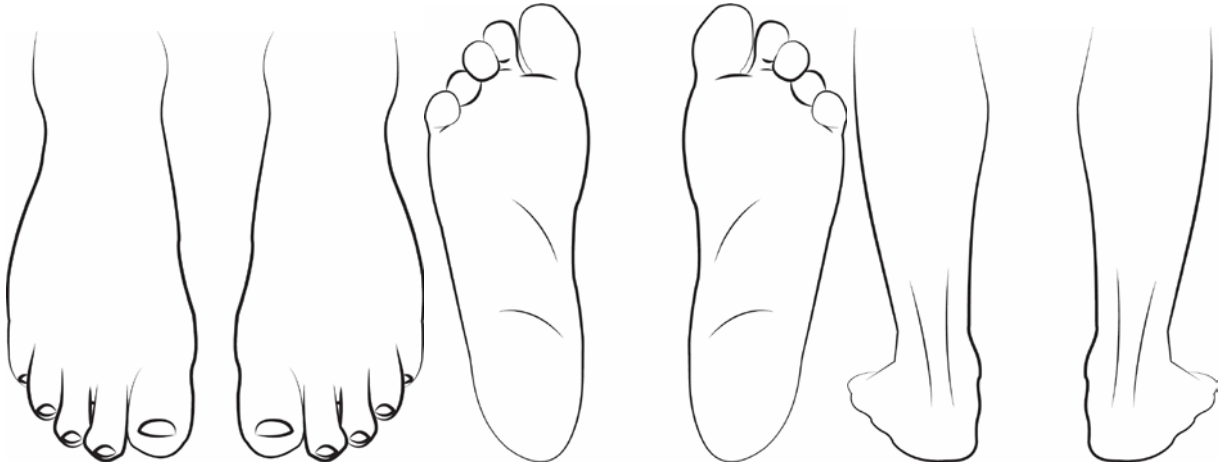
- Take medication that increases sensitivity to sunlight
Have a seizure disorder that is triggered by light
Have hemorrhagic diatheses
Been injected with steroids in the past 2-3 weeks
Have a cancerous lesion(s) or history of cancerous lesions
Take anticoagulants
Are pregnant
Have HIV positive history
Have a pacemaker
Leukemia

Please list medications you are currently taking:

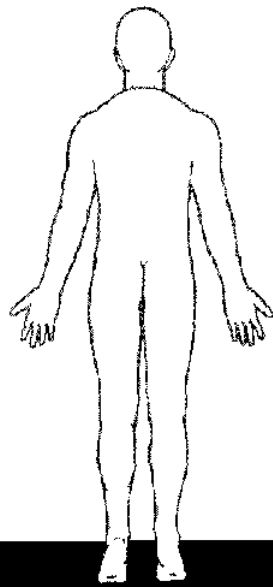
Medication list lines

Patient Signature: Date:

Please x any area of pain



Front



Back



Doctor's Notes _____



Prepare for your Treatment of Laser Therapy

- Make sure area of treatment is clean prior to your scheduled appointment
- Avoid the use of any topical creams, lotion, or analgesic balms before or immediately after treatment
- Wear approved safety goggles unless lying face down away from laser light (supplied by tech)
- Avoid wearing jewelry or any shiny objects (watches, bracelets, chains, etc.) at or around treatment area during treatment
- Wear appropriate (loose clothing) around treatment area (gowns will be supplied if necessary)

Insurance Coverage

MLS Laser Therapy is cleared for clinical use by the FDA; Insurance reimbursement is very limited at best, therefore, we do not participate with any insurance plans at this time. You may submit your paid receipt to your insurance company for consideration. The good news however, is that MLS Laser Therapy is very affordable to all who suffer with pain! Treatment cost begin at just \$\$\$ for a treatment and increase based upon the extent of the injury and the number of areas which require therapy.

I HAVE READ THE ABOVE PARAGRAPH, I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient Signature _____

Date _____