Laser Form

Date:____/____/____

Last Name:_____ First Name:_____

Date of Birth: DD / MM / YY AGE_____ Referred By:_____

Address:_____

City/Prov.:_____ Postal Code:_____

Home Phone:_____ Business Phone:_____ Cell:_____

Email:_____ Occupation:_____

Have you been diagnosed with cancer in the past 5 years? YES ☐ NO ☐

Are you currently pregnant or concerned about being pregnant? YES ☐ NO ☐

CONSENT FORM

You have requested to be treated with the Theralase Cold Laser Therapy. The laser used for this treatment has no thermal effect on tissue. Instead, this is a non-invasive laser which increased cell growth, faster wound healing, anti-inflammatory action, reduces fibrous tissue formation, increases metabolic activity, increases vascular activity, stimulates nerve function, etc.

Procedure: This therapy has been tested in several institutional review board approved studies in a double blind; placebo controlled fashion and found to be generally effective. All procedures carry risks, complications, and varied results as to the effectiveness of a particular treatment. The purpose of this document is to make you aware of the nature of this product and its potential risks in advance so that you have adequate information in your decision making process.

Benefits: Initially you will consult with the doctor your low energy laser therapy needs. During this time period you will have the opportunity to ask questions or voice concerns you may have concerning this treatment. Most patients achieve their goal after completing a minimum of five treatments; however, more may be necessary.

Risks: There are few risks associated with low energy laser therapy. This treatment is non-invasive and produces no heat within your tissue. During treatment no discomfort will be present, you will not feel the laser, and however, the light will be visible. The only known potential risk with the use of the laser device is that long-term exposure to laser light could cause damage to eyesight. You will be provided with **protective eyewear** and to avoid this risk, you must wear them during the treatments. Please inform us if you think you are pregnant, or are unsure if you may be pregnant, as a pregnancy test may be required to proceed with treatment. Although no known detrimental risks exist, potential unknown risks may exist. If you have a pacemaker, this treatment may not be right for you. It is recommended that one does not treat directly over a pacemaker or its lead wires. No known risks exist, however potential unknown risks may exist. There are also a variety of other conditions such as a pre-existing congestive heart disease which would contra-indicate this treatment. It is possible that you may not see any improvement in your body shape or it may get worse. There also may be unknown risks associated with low energy laser therapy not discovered at this time.

I have reviewed this consent form. The purpose of this procedure, benefits, risks, has been fully explained to my satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment. I intend this consent form to cover the entire course of my treatment at Prairie Chiropractic.

_____ _____

Print Client's Name Signature of Client or Parent/Guardian

DATE: _____