ASPEN LASER

LASER THERAPY CONSENT & CONTRAINDICATION FORM

Aspen Class IV Laser Therapy Treatment

I hereby authorize and provide permission to perform an Aspen Class IV Laser Therapy treatment.

I understand that the Aspen Class IV Laser Therapy is a safe and non-invasive treatment and has been cleared by the FDA to emit photon energy for the relief of minor muscle and joint pain, muscle spasm, pain and stiffness associated with minor arthritis, promoting relaxation of muscle tissue, and increase local blood circulation.

I understand that every individual responds uniquely to laser therapy treatments. Some patients may see immediate results after the first treatment or depending on the severity of their condition, may require several treatments before they begin to feel results. Most patients experience a decrease in pain and an increase in range of motion within the first few hours (and up to 36 hours) from the first treatment.

Note: Increased soreness may occur after your first laser therapy treatment session. This is a normal healing phenomenon known as retracing. If soreness occurs following your treatment, use ice for 5 minutes every 30 minutes, and no more than 5 minutes every 30 minutes. Repeat the icing as necessary. If soreness persists after icing, please contact this office.

CONTRAINDICATIONS:

To the best of my knowledge, I may have, or am, one or more of the following:

- Are you pregnant? ☐ Yes ☐ No
- Do you have cancer? ☐ Yes ☐ No
- Have you had cancer within the past 12 months? ☐ Yes ☐ No
- Are you currently taking photosensitizing medications? ☐ Yes ☐ No
- If yes, can you be in the sun for 10 min.without having itchiness, redness, blotchiness or pigmentation issues? ☐ Yes ☐ No

PRECAUTIONS:

To the best of my knowledge, I may have one or more of the following:

- Do you have a pacemaker or other implanted medical device (morphine pump,neurostimulator, etc)? ☐ Yes ☐ No
  If yes, where is it located?
  ____
- Have you had steroid injection(s) within the past 7 days? ☐ Yes ☐ No
  If yes, where?
  ____
- Is your pain directly over an epiphyseal plate (growth plate) in children under 15 years of age. ☐ Yes ☐ No
- Is your pain over the Ovaries, Thyroid Gland or Testes? ☐ Yes ☐ No

EYE SAFETY

I understand that Class IV Therapy Lasers emit both visible and invisible light. Protective eyewear is necessary at all times during the treatment. I will not remove the Safety Goggles until the administrator of the laser has turned off the laser treatment and provided notification that it is safe to remove them. You may be asked to remove reflective objects, such as rings, metal watchbands, and jewelry prior to treatment with the laser.

ACKNOWLEDGEMENT

I have read and understand the foregoing. This Laser Therapy Consent Form applies to subsequent visits and treatments. I understand that there is no promise or guarantee regarding the results of the treatment, and that to achieve maximum clinical results, I may need multiple treatments.

Patient Name ______________________________ Date:____________
PLEASE PRINT

Patient Signature ____________________________________

Guardian Name ______________________________ Date: ____________
PLEASE PRINT

Guardian Signature ____________________________________

Health Care Professional ______________________________ Date: ____________
PLEASE PRINT

Health Care Professional Signature ____________________________________