LaserHealth® Solutions

PATIENT INFORMATION SHEET

Name: _____ Sex: M F

Full Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Dr.'s Name: _____ Dr. Phone: _____

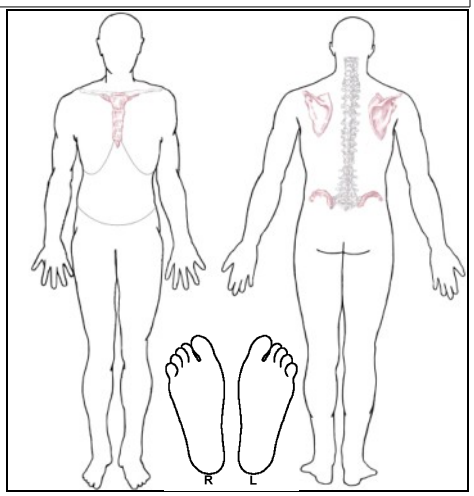
Date of Birth: _____ Age: _____ Email: _____

MONTH / DAY / YEAR

Your email address will only be used to send our informative monthly newsletters.

Current Health Habits	Yes	No	Patients Comments
Any recent steroid injections?			
Prescription and over-the-counter medications:			
Allergies?			
Exercise regularly?			
Females; Are you pregnant?			
Sleeping posture ☐side ☐stomach ☐back			

Do you have a history of: ☐Heart Disease ☐Arthritis ☐Cancer
☐Blood Clots ☐Hepatitis ☐Seizures ☐HIV ☐Herpes
☐Circulation problems ☐Diabetes Type: ___ ☐Other



Describe your pain / condition and mark it on the diagram: _____

_____

Pain or problem started on? _____

Pains are: ☐Sharp ☐Dull ☐Constant ☐Intermittent ☐Numbness/Tingling

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is the condition worse during certain times of the day? _____

Is this condition interfering with your work? _____ Sleep? _____ Routine? _____ Other? _____

Is the condition getting progressively worse? _____

Have you seen any other doctors for this condition? _____

Any effective treatments? _____

Have you experienced any side effects from the drugs and/or surgeries? _____

1) Please rate your pain by circling **TWO numbers** that **best** describes **your pain at its BEST** and **at its WORST** in the **past week**.

0 1 2 3 4 5 6 7 8 9 10
No Pain Intolerable Pain

2) Circle the **one number** that best describes how, during the **past week**, pain has **interfered with your general activity**.

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

Can LaserHealth® Solutions contact your doctor regarding your laser therapy treatments? ☐Yes ☐No

How did you hear about LaserHealth® Solutions? _____

LaserHealth® Solutions

INFORMED CONSENT TO LOW INTENSITY LASER THERAPY (LILT)

LOW INTENSITY LASER THERAPY CONTRA-INDICATIONS

1. DIRECT IRRADIATION OF THE EYES

Class 3B lasers are potentially harmful if viewed directly. When using 3B lasers the patient and practitioner must wear approved safety eyewear. This is not a requirement for the LED treatment heads.

2. PREGNANCY

Do not treat over the pregnant uterus. LILT may be used on the pregnant woman over other areas of the body.

3. CARCINOMA

Do not treat directly over any known primary or secondary lesions. Treatments may be given for pain relief during the terminal stages of the illness with the consent of both patient and consultant involved.

4. IMMUNE SUPPRESSANT DRUGS

Treatment is contra-indicated for patients on these drugs as LILT treatments positively affect the immune system.

REACTIONS TO TREATMENT

Occasionally some patients may experience a slight increase in pain. This is not necessarily an adverse reaction and may be a consequence of increased blood flow or change in metabolic activity that subsides in 24-48 hours.

Please advise us if you have photo sensitivity reactions to being in the sun (i.e. rash) or if you are taking medications causing photo sensitivity side effects (i.e. Tetracycline and Accutane).

LOW INTENSITY LASER THERAPY PRECAUTIONS

1. STEROID INJECTIONS

Patients may suffer an exacerbation of symptoms after LILT treatments in conjunction with a recent steroid injection. For this reason laser should not be used within 2 weeks of a steroid injection on or near the same site.

2. N.S.A.I.D. AND STEROIDAL A.I.

Patients using topical or systemic steroids or N.S.A.I.D.'s for pain or skin conditions may experience a mild "flare up" of their symptoms. If such a reaction occurs, laser therapy should be stopped and the reaction allowed to settle. LILT treatment can then be continued at half-minimum treatment times, building up to an effective dose.

3. ANTI-INFLAMMATORIES

Patients taking anti-inflammatories for acute soft tissue injuries will not respond as quickly to LILT treatment as those who are not. Ideally, we would recommend an ice pack followed by LILT treatment rather than the use of an anti-inflammatory in the acute stages.

I acknowledge I have discussed, or have had the opportunity to discuss, with my Laser Therapist the nature and purpose of LILT in general and my treatment in particular as well as the contents of this consent. I consent to LILT offered or recommended to me by my Laser Therapist. I intend this consent to apply to all my present and future LILT treatments.

MM/DD/YYYY

_____ _____

Date Signature of Patient (or Parent/Guardian)

_____ _____

Witness Print Patient's Name

LaserHealth® Solutions
Pain and Soft Tissue Rehabilitation

Fee Schedule

Laser Therapy is not covered by Provincial Health Care. If you have private health care insurance, Laser Therapy may be covered. Payment is due once service is rendered and it is the patient's responsibility to get reimbursed for any services that may be covered under their extended health benefits.

Payment can be made by **Visa, Master Card, Debit, Cash**, or **Personal Cheque**.

Assessment Fee

$50.00

Laser Therapy Fees

The fees for Laser Therapy vary, depending on the area being treated.
Generally the following fees apply **per treatment area (e.g. both feet = 2 treatments)**:

30 minutes - $50 *	**45 minutes - $75 ***	**60 minutes - $100 ***
Elbow Hand **Ankle Wrist** **Foot TMJ**	**Shoulder** **Whiplash** **Knee Neck**	**Low Back** **Hip**

*Note that some conditions such as sprains & strains, sports injuries, motor vehicle accidents, and acute injuries may require additional time.

Many conditions respond better when treated with a combination of Laser and Manual Therapy. Your Laser Therapy treatment time may include Low Intensity Light Therapy **AND** a combination of manual techniques such as massage (transverse friction or trigger point), mobilizations, joint stimulation, vibration, muscle re-education, taping, bracing and teaching of stretches and exercises. Based on your condition, your progress, and at the discretion of your therapist / clinician, your treatment time may consist of solely laser therapy or a **COMBINATION** of laser therapy and any of the manual therapies described above.

Please note that visits cancelled with less than 24 hours notice will be subject to a fee equal to the amount that would be billed for that visit.

I, _____, have read the above and fully understand LaserHealth® Solutions' billing policy.

Signature: _____ Date: _____MM/DD/YYYY_____

LaserHealth® Solutions
Pain and Soft Tissue Rehabilitation

Appointment Policy

Please reserve your laser appointment program. This minimizes missed appointments due to lack of available booking times.

To reschedule an appointment, 24 hours notice is required. This is in consideration for other patients who may require that treatment time.

A $25 missed appointment fee will be applied to your account if 24 hours is not given.

Payment can be made by **Visa, Mastercard, Debit, Cash** or **Personal Cheque.**

I, _____, have read the above and fully understand Laser Health Solution's Burnaby Appointment policy.

Signature: _____ Date: _____

Parking Policy

All Laser therapy patients parking in the parking lots must purchase a parking ticket for each appointment ($2.00 per hour).

Please be aware, you may park in any UNRESERVED space. If you are parked in any RESERVED space, YOU WILL LIKELY GET A PARKING TICKET.

I, _____, have read the above and fully understand Laser Health Solution's Burnaby Appointment policy.

Signature: _____ Date: _____

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