



515.967.6500 | BondurantChiro.com



# PATIENT REGISTRATION

## MLS<sup>®</sup> Laser Therapy

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail address \_\_\_\_\_ Date of Birth \_\_\_\_\_

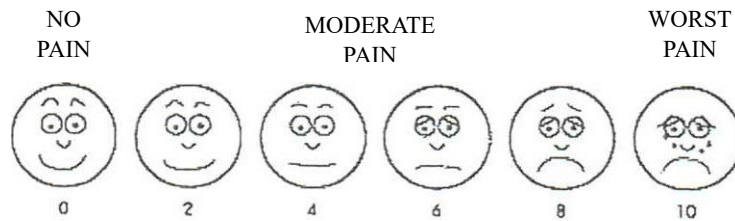
Primary complaint \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Length of time with this condition \_\_\_\_\_

How did you hear about MLS Laser Therapy? \_\_\_\_\_



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

Please check any of the following that apply to you:

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

Please list medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

For office use only:

Diagnosis \_\_\_\_\_

Notes \_\_\_\_\_

Tx plan: Number of visits Payment Plan: Individual Pay in full Appointment Schedule:

#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ #5 \_\_\_\_\_ #6 \_\_\_\_\_



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### 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 (bio stimulation), and 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 sessions;
- 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 Dr. Laura Mooney has deemed to be medically necessary in the care and treatment of my condition.

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

**HAVING KNOWLEDGE, I KNOWLING AUTHORIZE BONDURANT FAMILY CHIROPRACTIC TO PROCEED WITH MLS LASER THERAPY AND TREATMENT.**

DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Patient’s Name Printed                      Age

\_\_\_\_\_  
Patient’s signature OR  
authorized adult of minor

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date