chiropractic centre
for optimum health

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Informed Consent to Assessments and Cold Laser Therapy

I hereby request and consent to the performance of assessments, various modes of physical therapy, laser therapy, and other procedures, on me by the practitioners listed at this clinic and or anyone working at this clinic authorized by the practitioners. I have had the opportunity to discuss the nature and purpose of assessments, various modes of physical therapy, laser therapy and other procedures. I understand that results are not guaranteed.

I understand that cold laser therapy is a medical treatment that uses specific wavelengths of light to impart energy into injured cells and tissues. This energy is transformed from photon energy to biochemical energy in the cells which can then be used for repair processes in the body. The expected direct outcomes from laser treatment may include reduced inflammation, reduced pain, and repair of tissues. The indirect outcomes may include increased ranges of motion, comfort and activity levels. Alternatives to cold laser therapy include, but are not limited to, exercise therapy, anti-inflammatory or anti-pain medication, ultrasound, massage therapy, chiropractic or physiotherapy.

I further understand and am informed that, as in all health care, in the practice of cold laser therapy there are some risks, including but not limited to short term aggravation of symptoms and skin irritation. When used in combination with certain medications laser therapy can cause rashes or burns and I therefore understand that I must disclose all information on my current medications to the practitioners at this clinic. Treatment over active cancer may increase the rate of tumor growth; I understand that I must disclose any history of cancer. I also understand that the laser can cause damage to the eyes when viewed directly and that laser safety eyewear, supplied by this clinic, must be worn by me during laser treatments. The risks of not having laser treatments include, but are not limited to, ongoing pain and inflammation, development of scar tissue, development of degenerative changes, and reduction in daily activities and overall comfort.

I do not expect the practitioners listed at this clinic to be able to indicate or explain all risks and complications and I wish to rely on the exercise of judgment during the course of assessment and/or procedures which the practitioners feel at the time, based upon the facts known, is in my best interest.

I consent to the assessments, various modes of therapy, including but not limited to laser therapy, offered or recommended to me by the practitioners in this clinic. I intend this consent to apply to all my present and future care in this clinic.

Dated this_____day of_____, 20_____.

Patient/Guardian Signature: Signature of Witness:

_____ _____

Name of Patient: Name of Witness:

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