Luma PAIN RELIEF LASER CENTER

PATIENT INFORMATION FORM

DATE: / /

PERSONAL INFORMATION:

Full Name:			DOB:
SSN#:	Age:	Gender: ☐ Male ☐ Female ☐ Other	
Home Address:			
Cell Phone:		Home Phone:	
Email:		May we call, text, or email reminders? ☐ Yes ☐ No	

EMERGENCY CONTACT:

Name:	
Relationship:	Phone#:
Do you have a legal guardian or healthcare power of attorney? ☐ Yes ☐ No	
If yes, Name:	
Relationship:	Phone#:

Primary Care Doctor:	Phone:
How did you hear about us?	

PAIN HISTORY:

Please describe the pain/problem that you are currently seeking relief from:		
When did your pain first start (date), and what was the cause? Please be as specific as possible:		
Location(s) of Pain:		
On a scale of 0-10, where 0 is no pain and 10 is the worst pain imaginable, how would you rate your pain?		
Duration of Pain:	Describe Pain Type: ☐ Intermittent ☐ Constant	
What worsens your pain? (e.g., movement, pressure, time of day):		
What relieves your pain?		
Are you diagnosed with the current problem, seeking treatment? What diagnosed was given? Who diagnosed?		
Any prior treatments for the current problem?		
Any prior surgery for the current problem?		

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MEDICATIONS & ALLERGIES:

Please list all medications you are currently taking:
(include prescriptions, over the counter meds and herbal supplements)

Name	Dose	How often Do you take?

MEDICAL HISTORY:

Do you have any of the following conditions? (Please check all that apply)

- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Stroke
- ☐ Seizures
- ☐ Blood Clot Problems
- ☐ Weakness in Arms or Legs
- ☐ Bowel Problems
- ☐ Bladder Problems
- ☐ Currently Pregnant
- ☐ Weight Loss in the past 6 months
- ☐ Night Sweats/Fevers in the past 6 months
- ☐ Pregnancy
- ☐ Cancer, if YES what type/location: _____
- ☐ Other: _____

Do you have Pacemaker, Defibrillator or any other electric inplant? ☐ Yes ☐ No

Details: _____

ALLERGIES:

- ☐ Medications:
- ☐ Anesthesia: ☐ Foods
- ☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ None Known ☐ Other:

SURGERIES HISTORY:

	TYPE OF SURGERY	DATE
1		
2		
3		
4		
5		

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PATIENT INFORMATION FORM

SOCIAL HISTORY:

Marital Status:	☐ Single	☐ Married	☐ Partnered	☐ Separated	☐ Divorced	☐ Widowed
Use of Alcohol:	☐ Never	☐ No longer use	☐ History of alcohol abuse			
Current USE - Type:		☐ Rare	☐ Daily	☐ Moderate	☐ Occasional	
Use of Tobacco:	☐ Never	☐ Quit-how long ago?				
☐ Smoke:	packs/day of:	Years				
Use of Recreational Drugs:		Type: ☐ Never	☐ Quit-how long ago?			

Employer:	Occupation:

CONSENT AND AGREEMENT:

I certify, to the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

I acknowledge that the information provided is accurate to the best of my knowledge. I understand that laser therapy is a non-invasive treatment that may require multiple sessions for optimal results. I agree to follow the treatment plan advised by the practitioner.

Print Name of Patient, Parent or Guardian

If other than Patient, Relationship to Patient

Signature:

Date:

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FINANCIAL AND NO-SHOW POLICY

DATE: / /

PLEASE INITIAL EACH LINE INDICATING YOUR UNDERSTANDING OF OUR POLICIES.

	PAYMENT RESPONSIBILITY At Luma Pain Relief Laser Center, we strive to provide high-quality Pain relief services to our patients. Please note that our **services are NOT covered by insurance**. Therefore, full payment is required at the time of service. Patients are responsible for all charges related to their treatment.
	CANCELLATION POLICY: Your therapist allocates a specific amount of time for your appointment in order to meet the needs of your rehabilitation program. We understand there are times when you must miss an appointment, but request that you give us **24-HOUR NOTICE**. We charge **$50.00 for cancellations** when less than 24 hours' notice as well as missed appointments. This fee is the patient's responsibility and will be billed directly to the patient.
	PAYMENT METHODS: We accept cash, credit/debit cards, and checks as accepted forms of payment. Payment is due at the time of service unless prior arrangements have been made.
	REFUND POLICY: All sales for our services are final. We do not offer refunds or cancellations once services are rendered or initiated. Please ensure you are fully satisfied with your selection before proceeding.
	ADDITIONAL POLICIES: Returned checks will incur a fee of $35. Outstanding balances must be settled prior to future appointments.
	CHAPERONE POLICY: Some physical examinations and treatments will be highly focused, and the patient will be fully clothed; in other cases, the patient may be partially unclothed. In every case, patients are free to request a chaperone. The chaperone may be a patient advocate or an authorized health care professional. The health care professional will at all times adhere to the standards of confidentiality consistent within Luma Pain Relief Laser Center, LLC. By receiving services at Luma Pain Relief Laser Center, you agree to the financial, additional and chaperone policies. I have read the above statements. It is my understanding that I am financially responsible for the services provided to me or my dependent. I agree to pay the full amount of all charges incurred by the below-named patient.

Name of Patient or Legal Representative **Date**

Signature of Patient or Legal Representative

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CONSENT TO TREAT FORM

DATE: / /

Patient Name:	DOB:

WHAT IS THE REMY CLASS IV LASER THERAPY?

The Remy Class IV Laser Therapy is a safe and effective therapy that is FDA-cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. The primary effects of The Remy Class IV Laser Therapy treatments are increased circulation, the release of more oxygen from the bloodstream and enhanced utilization of that oxygen to increase ATP production. Mitochondria are a likely site for the initial effects, leading to increased ATP production, modulation of reactive oxygen species and induction of transcription factors. These effects lead to increased cell proliferation and migration, modulation of cytokines levels, growth factors and inflammatory mediators, and increased tissue oxygenation. Cell permeability is also enhanced/increased. Basically, laser therapy can help with tissue repair most notably in chronic pain/injury.

Studies have also shown that laser promotes accelerated nerve regeneration and improved functional recovery of peripheral nerves (ie. diabetic neuropathy).

HOW MANY TREATMENT SESSIONS WILL I NEED?

The number of The Remy Class IV Laser Therapy sessions you will need depends on the nature and duration of your condition, and other factors. Some acute conditions will respond in 6 or fewer sessions, whereas chronic conditions may take 15 or more treatments. Some chronic conditions require ongoing care to sustain pain relief and functionality.

TREATMENT COSTS?

Treatment cost is	with a package consisting of

WHAT DOES IT FEEL LIKE TO GET TREATMENT?

Most patients describe it as a very soothing, warm sensation. Since The Remy Class IV Laser Therapy is a high-powered therapy laser, your skin will get warm during the treatment. Many patients feel a significant reduction in pain on the first visit. Occasionally, patients will feel slightly more pain immediately after the treatment- and then feel much better the next day.

HOW WILL I FEEL AFTER THE TREATMENT?

You may feel pain relief after just the first treatment. For other patients, it takes a while longer. Most patients report, feeling very relaxed, or even tired. If you feel a lot less pain, keep in mind that pain reduction is just one goal. The Remy Class IV Laser Therapy gives your body cells more energy, so they repair and regenerate new tissues. The effect of The Remy Class IV Laser Therapy treatments is cumulative. You will be getting more benefit with successive treatments.

DO I NEED TO TAKE SPECIAL PRECAUTIONS AFTER MY REMY CLASS IV LASER THERAPY TREATMENT?

One effect of the Remy Class IV Laser Therapy treatment is vasodilation- which means your blood and lymphatic vessels have a larger diameter. This helps with inflammation reduction, but for some people vasodilation can also make them sore. Use ice on the area, as directed by your doctor. You could use pain relief gel, such as Bio freeze.

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CONSENT TO TREAT FORM

I FEEL A LOT BETTER-BUT I STILL HAVE SESSIONS REMAINING IN THE REMY CLASS IV LASER THERAPY TREATMENT PACKAGE I BOUGHT. WHAT SHOULD I DO?

Pain relief is just one goal in your care. The Remy Class IV Laser Therapy treatments help your body's repair and regeneration processes. Completing your Remy Class IV Laser Therapy session package will further assist the healing processes. We suggest that you use all the treatments in the package, to ensure the most effective care possible.

WHY DO I HAVE TO WEAR SAFETY GLASSES DURING MY REMY CLASS IV LASER THERAPY TREATMENTS?

The Remy Class IV Laser Therapy is a high-powered therapy laser. Laser light can be focused by the lens of your eye and potentially cause damage to your retina. The safety glasses you wear specifically block out the wavelengths of light produced by the Remy Class IV Laser Therapy.

ARE THERE CONTRAINDICATIONS OR PRECAUTIONS TO THE REMY CLASS IV LASER THERAPY TREATMENT?

- Temporary increase in pain during application of laser
- Temporary increase in pain the following day after laser therapy
- Mild bruising from vasodilation or direct pressure of laser tip
- Temporary dizziness
- Reaction when photosensitizing drugs are used with laser therapy

WHY DO I HAVE TO SIGN A CONSENT FORM?

Pain can increase temporarily. Bruising and/or swelling are also possible. We want you to be informed of all aspects of this treatment.

By signing below, you acknowledge that you understand and accept the risks, benefits, and cost of The Remy Class IV Laser Therapy treatment; and consent to having this therapy administered.

Patient Name **Date**

Signature