Eastern Medical Health Group

Low-Level Laser Therapy Informed Consent Form

INSTRUCTIONS: This is an informed consent document that has been prepared to help your healthcare provider inform you concerning low-level light therapy treatments, the potential risks involved and result expectations. Please be advised that this is not a surgical procedure. It is important that you read this information carefully and completely and sign the consent for Laser treatments, as proposed by your healthcare provider, acknowledging that you have read and understand the nature of the treatments and consent to receiving such treatments.

INTRODUCTION: Hair Growth Laser Therapy (also referred to as Low Level Laser Therapy) is the use of a Cold laser device for the purpose of re-growing hair. Effective in 95% of all hair loss, we utilize the Sunetics brand clinical laser. The Sunetics Hair Growth Laser is the first clinical laser to be FDA cleared to grow hair and treat hair loss in both men and women. The Sunetics Laser uses Low Level Laser Therapy to stimulate the hair follicles, healing them and helping them to regrow into thick, normal sized hairs. Their FDA Cleared technology offers no pain, no drugs, no surgery and no side effects.

PROCEDURE: Unless modified by your healthcare practitioner, treatment sessions consist, each, of 20-minute increments. The total amount, and frequency, of visits within a course of treatments will depend on the condition(s) treated and their severity. This will be determined at the time of the initial consultation. Should additional treatments augment the desired results, the practitioner will discuss them with you.

BENEFITS: Studies show that Low Level Laser Therapy is able to increase the production of ATP to energize & repair the weakened follicle; increase blood micro-circulation to the follicle; increase the nutrient acquisition by the follicle; increase oxygen uptake and calcium ion mobilization; increase the rate of removal of harmful DHT; decrease follicular inflammation. The increase in cellular activity and removal of harmful DHT allows the follicle to heal and regrow normal, healthy hairs.

CONTRAINDICATIONS: Not for use over known cancer tumor or metastasis or any other skin related cancer; avoid with patients taking cortisone or other steroidal injections in the area, any skin sensitivity or condition that renders skin sensitive to exposure to concentrated light or light therapies; avoid patients taking photosensitive drugs; eye protection can be recommended but not required; staring directly into laser is prohibited to avoid possible damage to eyes.

DISCLAIMER: Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your healthcare provider may provide you with additional or different information, which is based upon all the facts in your particular case and present state of knowledge within this field. It is important that you read the above information carefully and have all of your questions answered before signing the following consent.

CONSENT FOR LOW LEVEL LASER THERAPY TREATMENT

1. I hereby authorize EASTERN MEDICAL HEALTH GROUP, it's assigned practitioners, and such assistants as may be selected to perform low-level light therapy treatments. I have received the LOW-LEVEL LASER THERAPY INFORMED CONSENT FORM.
2. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained
3. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
    A. THE ABOVE TREATMENT OR EXPOSURE TO BE UNDERTAKEN
    B. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
    C. ANY POSSIBLE RISKS TO THE PROCEDURE OR TREAMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-3). I AM SATISFIED WITH THE EXPLANATION

_____ _____

Patient (or Person Authorized to Sign for Patient) Authorized signature for Eastern Medical Health Group

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Date Date