

**PATIENT RELEASE FORM**

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_

***I, the undersigned, desire to obtain treatment and services from Joseph D. Oberholzer MSPT. My provider will perform treatment procedures in accordance with the professional codes governing Physical Therapy. I deny any cancer, tumors, and/or blood clots and am not currently pregnant. I release Cold Laser Pain Therapy LLC and its affiliates, its Board of Directors and Officers, and its medical staff of any and all liabilities surrounding the treatment and application of procedures and services.***

\_\_\_\_\_  
(Patient Signature) (Date)

***I authorize Cold Laser Pain Therapy Inc. to use my name in testimonials regarding outcomes of treatment.***

\_\_\_\_\_  
(Patient Signature) (Date)

# PATIENT INFORMATION FORM

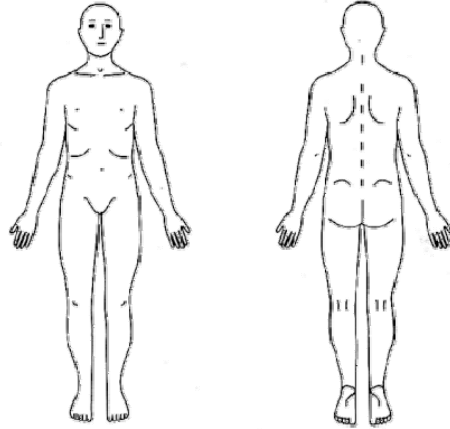
Name \_\_\_\_\_ MR # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_

In order to assess whether you are a candidate for cold laser therapy and provide the most effective treatment, please be as accurate as possible when providing the information below.

1) Circle a number that best describes your pain level:



Draw a dot on the **MOST** painful spot:



2) What caused your pain? \_\_\_ Unknown  
 \_\_\_\_\_

3) I have had this pain for:  
 \_\_\_day(s)\_\_\_week(s)\_\_\_month(s)\_\_\_year(s)

4) My pain is getting \_\_\_better\_\_\_worse\_\_\_staying the same.

5) My pain is: \_\_\_constant\_\_\_intermittent

6) Words that describe my pain:  
 \_\_\_stabbing\_\_\_shooting\_\_\_throbbing  
 \_\_\_burning\_\_\_nagging\_\_\_radiating  
 \_\_\_deep\_\_\_dull\_\_\_crampy\_\_\_numb

9) Please list treatment(s) you have tried to alleviate pain:  
 \_\_\_Meds\_\_\_Surgery\_\_\_Physical therapy  
 \_\_\_Pain management\_\_\_Chiropractic

7) My pain interferes with:  
 \_\_\_sleeping\_\_\_sitting\_\_\_standing\_\_\_walking  
 \_\_\_running\_\_\_bathing\_\_\_driving\_\_\_other \_\_\_\_\_

10) Have you had or are you currently under  
 the care of a physician for the diagnosis of:  
 pregnancy\_\_\_cancer\_\_\_tumor(s)\_\_\_blood clot(s)\_\_\_

8) Past Medical History: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
*Patient (Signature)*

\_\_\_\_\_  
*(Date)*

## Patient completes after treatment:

Please reassess your pain level:



Describe your experience with the ML830 Laser@:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Clinician's name (print): \_\_\_\_\_

Clinician's signature \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Use or Disclose Protected Health Information  
Cold Laser Pain Therapy, LLC**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Request: \_\_\_\_\_

**As required by the Privacy Regulations, Cold Laser Pain Therapy, LLC may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

1. Patient Health Information authorized to be disclosed **of past and current medical history.**
2. For the specific purpose **of providing the clinician with medical information pertinent to the application of cold laser treatment.**

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**Effective dates** for this authorization: **30 Days from evaluation date**

This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

**I understand I have the right to:**

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

\_\_\_\_\_  
*Signature or Patient or Patient's Authorized Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Authorized Signature of Facility*

\_\_\_\_\_  
*Date*

## **TREATMENT INFORMATION**

The ML 830 Cold Laser® resolves inflammation, associated pain and stimulates, organizes, and accelerates the body's natural healing process. The ML 830 laser® is safe and FDA approved with the only contraindication warning "No direct contact with the eyes".

### **What to expect during cold laser treatment:**

- The treatment is completely noninvasive and painless, but you may experience some local warmth and tingling in the treatment area or your extremities.
- Treatment time normally takes approximately 30 to 45 minutes per pain region.

### **What to expect following your cold laser treatment:**

- There is no guarantee of a successful outcome with any medical treatment. However, most patients feel some degree of pain relief after their first cold laser treatment. You may experience some residual tightness and/or soreness in and around the treated area which may last for several days.
- Once you receive a cold laser treatment, the healing process stimulated by the laser will continue for the next 10 to 12 hours.
- Results will vary depending on the severity and chronicity of your condition.
- Treatment with the ML830 laser® does not "wear off". If you respond to cold laser therapy and do not re-injure the area, your pain should not return.
- In most cases, you will need multiple treatments to completely abolish your pain.
- You may experience residual tightness and/or soreness in and around the treated area for several days.

### **Do's and Don'ts following a cold laser treatment:**

#### **DO NOT:**

- Engage in physically stressful activities for several days following treatment. Cold laser works quickly to resolve pain and swelling. Your body may need time to accommodate to an increase in activity level.

#### **DO:**

- Protect the treated area for several days following treatment.
- Drink water and rest frequently.

Patient's Signature \_\_\_\_\_

Clinician's Signature \_\_\_\_\_