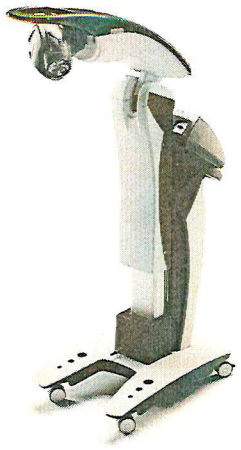


Existing Patient Registration

MLS Laser Therapy

Name _____

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

E-mail address _____ Date of Birth _____

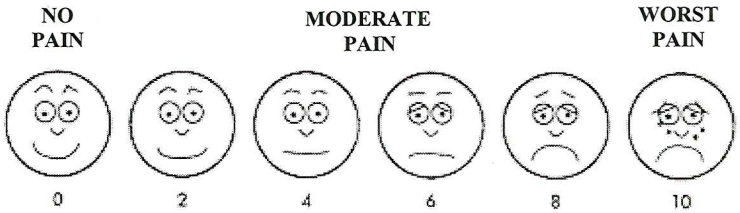
Primary complaint _____

_____

_____

Length of time with this condition _____

How did you hear about MLS Laser Therapy? _____



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

Have you ever been diagnosed with cancer? Y/N, explain: _____

Do you have an implanted neurostimulator device? Y/N, where: _____

Do you have a pacemaker? Y/N _____

Please check any of the following that apply to you:

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

Please list medications you are currently taking:

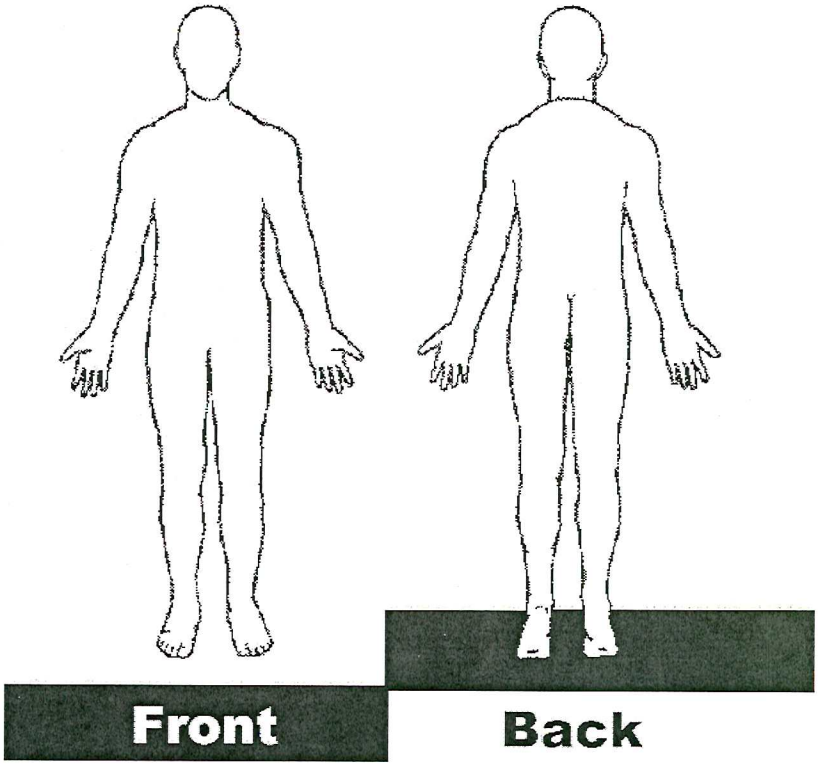
_____ _____

_____ _____

_____ _____

Patient Signature: _____ Date: _____

Please x any area of pain



Doctor's Notes _____

_____

_____

_____

Prepare for your Treatment of Laser Therapy

- Make sure area of treatment is clean prior to your scheduled appointment
- Avoid the use of any topical creams, lotion, or analgesic balms before or immediately after treatment
- Wear approved safety goggles unless lying face down away from laser light (supplied by tech)
- Avoid wearing jewelry or any shiny objects (watches, bracelets, chains, etc.) at or around treatment area during treatment
- Wear appropriate (loose clothing) around treatment area (gowns will be supplied if necessary)

Insurance Coverage

MLS Laser Therapy is cleared for clinical use by the FDA; Insurance reimbursement is very limited at best, therefore, we do not participate with any insurance plans at this time. You may submit your paid receipt to your insurance company for consideration. The good news however, is that MLS Laser Therapy is very affordable to all who suffer with pain! Treatment cost begin at just $$$ for a treatment and increase based upon the extent of the injury and the number of areas which require therapy.

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

Patient Signature_____ Date_____

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 (biostimulation), 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 session;
- 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. Darren Woodling has deemed to be medically necessary in the care and treatment of my condition.

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

HAVING KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. WOOLDING AND HIS STAFF TO PROCEED WITH MLS LASER THERAPY AND TREATMENT.

DATED THIS _____ DAY OF _____, 20 ___, *Troy, Al.*

_____ _____

Patient's Name Age of Minor

Patient's Signature OR
Authorized adult of minor

_____

Signature of Doctor