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XLR8 COLD LASER THERAPY INFORMED CONSENT

XLR8 Cold Laser Therapy is an FDA-cleared, non-invasive, fast and effective modality that has been proven in clinical trials to reduce pain, reduces edema, and promotes healing. It is scientifically-proven to relieve pain up to 70%. It works by using low intensity photonic energy as a treatment modality. Photonic stimuli excite the body's cells infusing them with energy, with the three primary reactions being, reduction of inflammation, cell regeneration, and increased blood flow.

The potential uses of the XLR8 are almost limitless; the manufacturer *Erchonia* has received market clearance for pain. It continues to conduct clinical trials on other applications. There are other off-label applications.

There are no code-regulated contraindications in the use of Low-Level Laser therapy. Although no known detrimental risks exist, potential unknown risks may exist. There are no known and/or published adverse effects. Since there are no long-term evaluations on certain conditions, *Erchonia* does not recommend its use on pregnant women or persons with a pacemaker. Other contraindications include a defibrillator, electrical stimulator, and active cancer. Should you have any of these conditions, please inform the physician or medical staff.

Alternative treatments are available which may have their own risks and benefits.

I have reviewed this XLR8 Cold Laser consent form. My consent and authorization for this procedure are strictly voluntary. The treatment results vary and there is no guarantee that the desired results will be achieved.

By signing below, I grant authority to Dr. Eileen Comia and/or her staff to perform the described treatment or administer any related treatment as deemed necessary or advisable for my medical condition. I certify that I understand the contents of this informed consent form. I have had enough time to consider the information and feel I am sufficiently advised to consent to this procedure.

_____ Date of Birth: ___ / ___ / _____
Printed Name

_____ _____
Signature of Patient Date