



Patient Information

Name	Date of Birth:	
Name you preferred to be called:	Social Security #:	
Mailing Address		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Insurance CO:	Policy #:	
Employer:	Work Phone:	
E-Mail:		
Primary Care Physician:		
How did you hear about our clinic?		

WHERE is your Pain?
How LONG has your Pain been present?
What is Your AVERAGE Pain Score (1-10)

What Medical Evaluations/Tests have you had for your Pain?

What Treatments/Therapies have you tried for your Pain?

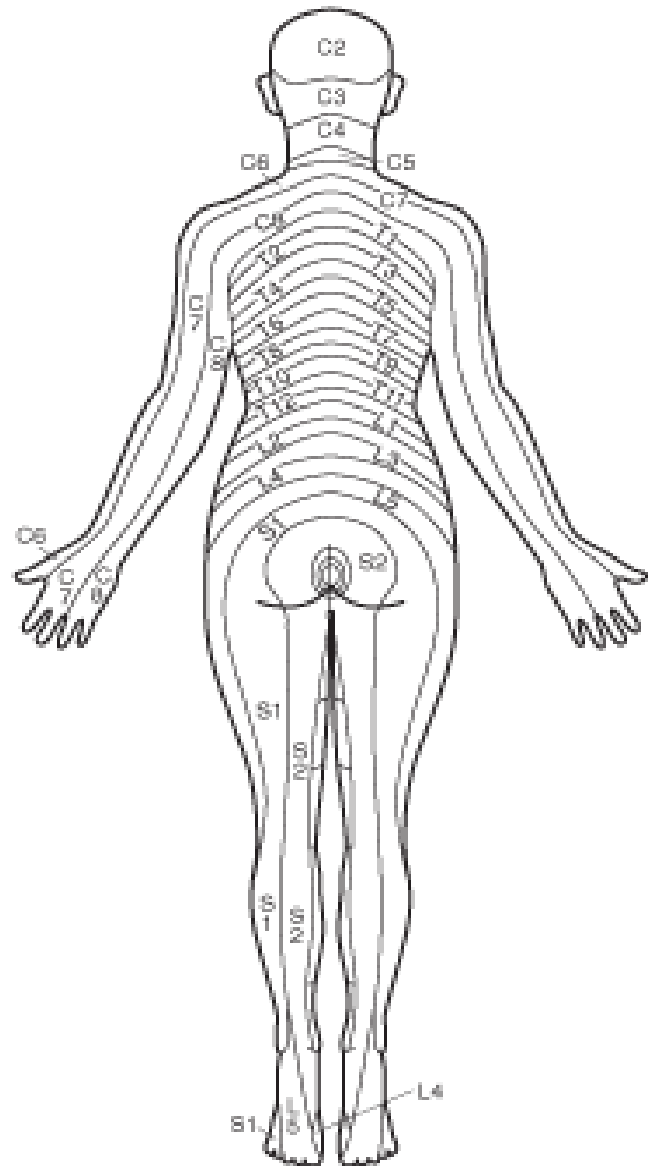
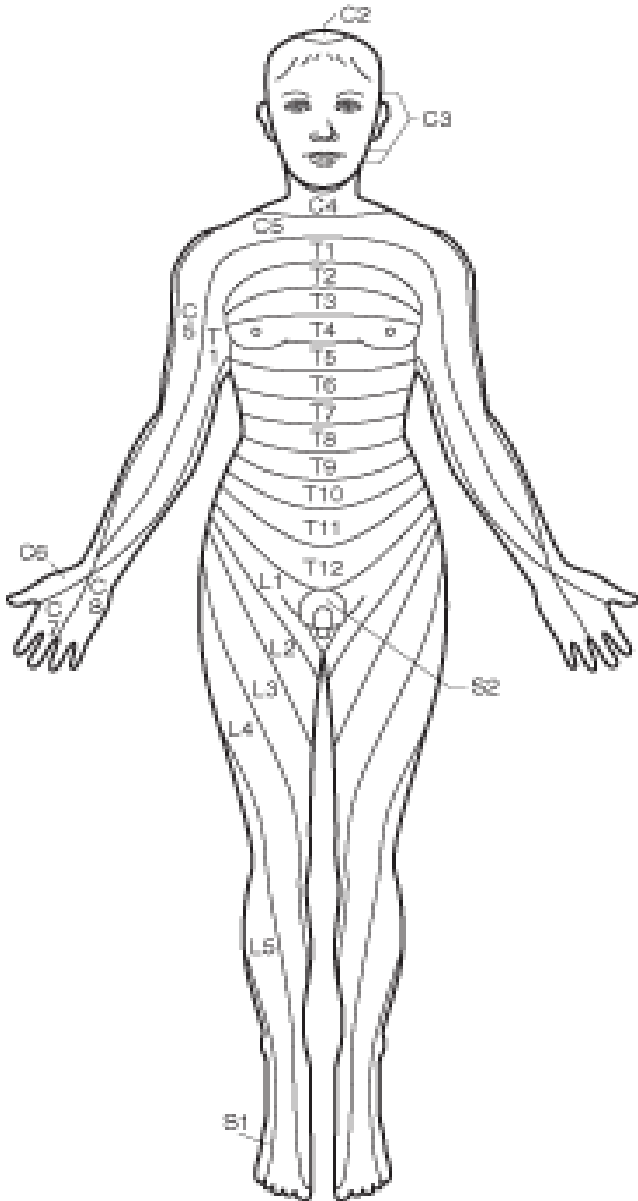
Have you had any surgeries for this Pain?
List all medications and dosages you currently use for Pain

Do you have a heart pacemaker or Defibrillator? YES NO

Patient Information

NAME

DOB



Please highlight in YELLOW the area(s) of the body where you experience pain.
Please place a black X over the area of most severe pain.



Treatments

1. Calmare® 10 Treatment Cycle - Our standard regimen is 5 treatments a week for two consecutive weeks for a total of 10 treatments. Studies have revealed that this treatment regimen provides the patient with the longest duration of pain relief. The cost of this treatment cycle is \$3,000. Cash discounts are available.
2. Intermittent “Boost” Treatments-after your initial 10 treatment session some patients may require a shorter course of 2-3 “boost” treatments on an intermittent basis to continue to experience pain relief. The cost of each boost treatment is \$150. Cash discounts are available.
3. Please contact us at 855-773-7677 to schedule a Calmare® 10 Treatment Cycle or Intermittent Boost Treatments.
4. We will bill your insurance. Co Pays & Balances may be paid by credit card, check or cash. Independent medical financing is available. Payment information is available upon request.

Treatment Instructions

1. Each treatment sessions lasts approximately 45 minutes.
2. Wear comfortable, loose-fitting clothing that allows easy access to the area of pain that needs to be treated. Gowns are available if needed but most patients feel more comfortable wearing their own clothing.
3. Avoid applying lotions, creams, powders or ointments.
4. Continue your medications that you currently use for pain. If you take Lyrica (Pregabalin) or Neurontin (Gabapentin) we may reduce your dosage as the treatment cycle continues.
5. Bring a book, magazine or music player to help you pass the time.



Consent to Treat

The undersigned is voluntarily agreeing to use, or have used upon him/her, the Calmare® Pain Therapy Medical Device, a treatment that, through the use of disposable surface electrodes imparts electrical impulses to the body for the purpose of stimulating artificial neurons that affect how the body detects, interprets or feels pain or painful sensation.

Because of the manner in which the Calmare™ Pain Therapy Device operates, you should not have the treatments if you suffer from or have any of the following. **Please Check:**

- | | |
|---|---|
| <input type="checkbox"/> Pacemaker or implantable defibrillator | <input type="checkbox"/> Are, or could you be, pregnant |
| <input type="checkbox"/> Wounds or skin irritation in areas where the electrodes will be placed | <input type="checkbox"/> Vena cava or aneurysm clips |

Risks of using this device include: No change in pain status, increase/exacerbation of pain, irritation/infection around electrode site and injury due to lack of pain. The use of any medical device could lead to severe or permanent injury or even death.

The voluntary use of this medical device is done at your own risk and with full knowledge of the above, as well as the risks incumbent with any medical device. You agree to release Spero Pain Relief Therapy, LLC from any and all damages, pain, conditions, diseases and any other harm that you may suffer or come to suffer, as a result of your use of this medical device. I agree that Spero Pain Relief may disclose information on me, including my medical records to any 3rd party payors, including, but not limited to health insurers, health care service plans, welfare agencies, worker's compensation carriers or my employer.

I authorize direct payment to Spero Pain Relief Therapy, LLC of any insurance benefit. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 90 days from the date of service.

It is understood and agreed that if I fail to pay my account within the parameters stated above and it becomes necessary to place my account with a collection agency, I will be liable for all the costs incurred for such services. By executing this document below, in addition to agreeing to all of the above, you represent and warrant that you are of legal age to enter into a legally binding agreement.

Printed Name

Date

Signature

Social Security Number

1-855-773-7677