**CLINIC NAME Light Therapy Services**

**Informed Consent**

**Credentials**

I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a Certified Light Therapist providing Light Therapy services and is not a medical doctor (MD).

**Disclaimer**

I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is not a licensed physician or medical practitioner and is not licensed to diagnose or treat specific diseases. If a medical diagnosis or treatment is required, it must be obtained by a licensed physician.

**Scope of Practice**

Light Therapy (aka photobiomodulation) is a process whereby the device emits a bandwidth of light to certain parts of the body. Light radiation must be absorbed to produce biological responses such as pain reduction and increased circulation. I understand that Light Therapy is only being utilized for the purpose of pain reduction and increasing localized circulation, as per the FDA guidance. It is not intended to treat or cure any disease.

**Benefits of Light Therapy**

The expected benefits from undergoing Light Therapy for areas upon which Light Tools are placed include pain reduction and a localized increase in circulation in addition to the stimulation of cellular respiration the production of new cells.

**Contraindications**

Light Therapy is non-invasive. It is important to notify the practitioner if your medical history changes, such as becoming pregnant or if you have been diagnosed with an unexpected medical condition.

**Please answer the following questions:**

* Do you have any contagious or infections conditions? 🞎 YES 🞎 NO
* Do you have chronic or medically controlled low blood pressure? Or are you taking blood thinners or ntirates such as nitroglycerin? 🞎 YES 🞎 NO
* Do you have a history of epilepsy? 🞎 YES 🞎 NO
* Do you have any malignant tissue, tumors, active carcinoma or other cancer? 🞎 YES 🞎 NO
* Do you have any areas of active bleeding? 🞎 YES 🞎 NO
* Are you currently pregnant or breastfeeding? 🞎 YES 🞎 NO
* Do you have any medical condition which makes you sensitive to light? 🞎 YES 🞎 NO
* Have you ever had a brain injury or concussion? 🞎 YES 🞎 NO

\* If you answered “Yes” to the brain injury question, how long ago did the injury occur and how severe was the injury? Answer below

\* If you answered YES to any of the above questions, you may want to consult with your Health Care practitioner before proceeding with Light Therapy. If you are choosing to proceed with Light Therapy without doing so, please sign and date this document.

**Confidentiality**

Your information will be kept confidential and will not be disclosed to anyone outside of this office without your written consent, unless required by law.

**Arbitration**

Any dispute, controversy or claim arising out of or relating to these services shall be exclusively resolved by binding arbitration upon a party’s submission of the dispute to arbitration, with arbitration fees to be shared proportionally between the parties.

**Consent**

By signing below, I agree that I have read and understand the above information. My questions have been fully answered to my satisfaction, and I have made an informed decision to undergo light therapy.

**Client Signature Print Name Date**

**Consent for Parents/Guardians of Minor Clients**

I attest that I have full legal authority to make decisions for the minor named below, and that I give my permission for him/her to undergo light therapy.

**Parent/Guardian Signature Print Name Date**

**Name of Minor Client Date of Birth**