Wellness Therapeutics

Name: _____ Phone Number: _____

Contraindications (Precautions) for Biosound Therapy

Seizure disorders and Schizophrenia are always contraindicated. **Out of an abundance of caution,** we recommend this patient waiver form for the following: **Pregnancy, Thrombosis, Recent Head Trauma, Pacemaker or Defibrillator, Seizure, Epilepsy or Schizophrenia.** The Biosound beds contain magnets and vibroacoustics which are relative contraindications to the conditions listed below.

Potential Contraindications for Red Light/Infrared Therapy

The Red Light Therapy is a newer form of therapy and does not have an absolute contraindications listed by the FDA or other regulatory agencies. Clinical knowledge and a growing body of research leads to some potential absolute contraindications as follows: **Recent Burns, Malignant Cancer, Hyperthyroidism, Pregnancy, Epilepsy, Eye Disease or Light Sensitivity.** In addition, some potential relative contraindications may be: **Fever or Infection, Systemic Lupus Erythematosus (SLE), Photosensitizing Medications.**

Please feel free to speak to a team member if you have any questions or concerns addressed and answered about the contraindications for the therapies provided through Wellness Therapeutics.

Are you pregnant or breast feeding?	Yes _____ No _____
Do you have a history of blood clots (Thrombosis)?	Yes _____ No _____
Have you had any recent head trauma?	Yes _____ No _____
Do you use a battery operated device? (Pacemaker/Defibrillator)	Yes _____ No _____
Do you have Schizophrenia?	Yes _____ No _____
Are you on medication that causes Light Sensitivity?	Yes _____ No _____
Do you have active Carcinoma?	Yes _____ No _____
Do you have Malignant Cancer?	Yes _____ No _____
Do you have Hyperthyroidism?	Yes _____ No _____
Have you had any recent burns or active bleeding?	Yes _____ No _____

I understand that participation in any activities/modalities provided by Wellness Therapeutics, LLC is at my own risk and that there may be inherent or unknown consequences with such services/modalities.

I am aware that I should seek advice from a licensed medical professional before beginning any treatments and assume any and all risk thereof.

I release Wellness Therapeutics, LLC and all employees from any liability of injuries due to, but not limited to, known or unknown use or effects of Delta Sleep System by Biosound® and/or Inlight Therapy therapies, including any travels after receiving services.

Client Signature: _____ Date: _____