Informed Consent

Name: _____ Date:_____

RED LIGHT THERAPY (AKA LLLT – Low Level Light Therapy or PBMT – Photobiomodulation Therapy)

- Always wear protective eyewear. Failure to wear protective eyewear may result in burns or long-term injury to the eyes.
- You should prepare your skin for your session prior to your arrival. For optimal results, skin should be free of deodorant, makeup, fragrances, oils, and lotions. Remove jewelry.
- Certain Medications or cosmetics may increase your sensitivity to the Red Light Therapy.
- For optimal results recommended red light therapy schedules are 1-3 days per week, for 4-12 weeks.
- After treatments sit up slowly to prevent dizziness.
- I am over 18 years of age.
- I understand that Red Light Therapy should not be administered to people with the following conditions, and I do not have any of these conditions.
  a.Persons diagnosed with basil cell carcinoma
  b.Pregnancy
  c.Epilepsy
  d.Thyroid Condition
  e.Taking medications that cause sensitivity to light (example: tetracycline)
  f.Broken or inflamed areas of the skin.

I understand that Red Light Therapy is not intended to take place of medical care or medications. To my knowledge, I have no medical condition which would prohibit me from using Red Light Therapy. I acknowledge that the results of Red Light Therapy do vary, and that no guarantees of specific results are offered or implied. I have been given adequate instructions for the proper use of the equipment, understand the risks involved, and use it at my own risk. I hereby agree to release the owners, operators, and manufacturers from any damages that I might incur due to the use of this facility.

Pre/Post Treatment Instructions:

It is important that the treated area (whole body) be clean, remove all moisturizers and creams, prior to starting any treatment session. In order to maximize your treatment, you must drink at least 8 oz. of water before and after all treatment sessions, practice healthy eating habits, alcohol consumption, and smoking while undergoing your series of light therapy sessions.
Most clients will continue to see improvements over weeks post initial sessions. As with any Red Light Therapy, individual results will vary from person to person and no guarantees can be made that expected or anticipated results will be achieved. I am aware that follow-up treatment(s) may be necessary for desired results. Most patients require a number of treatment sessions over several weeks with gradual results occurring over time.

Risks and Side Effects:

Red Light Therapy treatments are non-invasive and are intended not to produce any thermal damage or pain. Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. It is important to notify the treatment facility if you have any problems or concerns such as uncomfortable heat from the pad or panel, prolonged redness of the skin, swelling, itching or severe headaches during or after the treatment. These are all indications of sensitivity to light. These side effects rarely occur and usually subside within 24 hours of discontinuing the treatment. **I understand the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. Alternative treatment choices are available. With this in mind, I am choosing this non-invasive treatment option.**

If you have/had or use any of the following then you are not a candidate for red light therapy treatments.

Photophobia, Porphyria, Lupus Erythematosus, Exogenous Eczema, Eye Disease/Retinal Abnormalities, Epilepsy and Seizures, Hypomelanism (albinism), Heart Trouble/Pacemaker, Pregnant, Infectious or Contagious conditions.
*Please carefully look over the following list of medications and check off any you have taken in the past 7 days. These medications have been known to cause light sensitivity.

- Anti-Arrhythmic Amiodarone (Pacerone® Cordarone® Aratac®)

- Chlorpromazine (Thorazine®, Chloramead®, Chlordryprom®, Chlor® Promanyl®, Largactil®, Promapar®, Promosol®, Terpium®, Sonazine®)
- Acne Oral Isotretinoin (Accutane®, Accure®, Aknenormin®, Amnesteem®, Ciscutan®, Claravis®, Isohexal®, Isotroin®, Oratane®, Sotret®, Roaccutane®)
- Topical Isotretinoin (Isotrex®, Isotrexin®)
- Anti-Psychotic Haloperidol (Haldol®)
- Trifluoperazine (Stelazine®, Clnazine®, Novoflurazine®, Pentazine®, Solazine®, Terfluzine®, Triflurin®, Tripazine®)
- Anti-Fungal Griseofulvin (Grifulvin®)
- Antibiotics Tetracycline (Helidac®, Terra-Cortril®, Terramycin®, Sumycin®, Actisite®, Bristacycline®, Actisite®, Tetrex®, Doxycycline®, Ciprofloxacin®)
- Norfloxacin (Noroxin®, Quinabic®, Janacin®)
- Ofloxacin (floxin®, Oxaldin®, Tarivid®)
- Nalidixic acid (NegGam®, Wintomylon®)
- Ciprofloxacin (Cipro®, Ciproxin®, Ciprobay®)
- Minocycline (Minomycin®, Minocin®, Arestin®, Akamin®, Aknemin®, Solodyn®, Dynacin®, Sebomin®)
- Oxytetracycline
- Demeclocycline
- Lymecycline
- Cancer Methotrexate (MTX®, Aminopterin®, Ledertrexate®)
- Arthritis Auranofin (Ridaura®)

The above drugs are currently the most common medications associated with photosensitivity and are by no means a complete list of all photosensitive medications. Herbs and over the counter medications such as psoralen and St. John's Wort can also cause sensitivity to light, so it is important to disclose any and all medications or herbs you are currently taking.

I agree

I agree to adhere to any and all safety precautions and regulations during the treatment. I have read and understand the Pre and Post Treatment Instructions. I understand that compliance with recommended pre and post procedure guidelines are critical in determining the effectiveness of the treatment sessions. The nature and purpose of the sessions has been explained to me. I have carefully read and understand this agreement and fully understand its contents. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. **I understand the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks.**

I authorize Gentle Touch Therapy LLC and its clinician to perform Red Light Therapy treatments on me. I release Gentle Touch Therapy LLC and its clinician from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age and sign this at my own free will.

Signature: _____

Printed Name:_____

Date: _____