RED LIGHT THERAPY RELEASE/CONSENT FORM

CLIENT INFORMATION

Name (First & Last) _____ D.O.B. _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____

This machine treats your entire body in a relaxing 20 minute session and emits NO UV whatsoever. Red Light Therapy is characterized as a near infrared light, which is a unique type of light that has a stronger wavelength than other types of light. This enables it to penetrate deeper into the skin and provide many therapeutic benefits including improvement in the skin's appearance and structure as well as relief from pain. There is NO UV light associated with Red Light Therapy.

PLEASE READ THE FOLLOWING INFORMATION AND ACKNOWLEDGE THAT YOU DENY ALL CONTRAINDICATIONS AND THAT YOU UNDERSTAND AND ACCEPT ALL PROVISIONS BY SIGNING BELOW.

- Recent Burns
- Malignant Cancers
- Hyperthyroidism (Neck and Upper Chest Only)
- Epilepsy
- Pregnancy
- Eye Disease (Eyes Only)
- Light Sensitivity
- Fever or Infection
- Systemic Lupus Erythematosus (SLE)
- Severe Bleeding or Blood Loss
- Use of Photosensitizing Medications - antihistamines, coal tar and derivatives, contraceptives (oral and estrogen), NSAIDs, Phenothiazines, Psoralens, Sulfonamides, Sulfonylureas, Thiazide Diuretics, Tetracyclines, Tricyclic Antidepressants
- Protective Eye Wear - Failure to use FDA certified protective eye wear may result in severe burns or long term injury to the eye. I agree to wear protective eyewear.
- I understand that the more and longer period of time I use Red Light Therapy, the better results I may get. Furthermore, I understand that each individual reacts differently to this therapy.
- I understand that the use of Red Light/LED light therapy is not intended to diagnose, treat, cure or prevent any disease.
- Lotions and other products may cause your skin to be more sensitive to this unique type of light.
- I understand I cannot use Red Light Therapy but once during a 24 hour period.

To my knowledge, I have no medical conditions or allergy which would prohibit me from using Red Light/LED light therapy. I acknowledge that the results of Red Light/LED light therapy do vary, and no guarantees of specific results are offered or implied. Triad of Health LLC dba Downtown Gilbert Healthcare, will not refund or credit any amount of money because of a client's unhappiness with their final results. 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 damage that I might incur due to the use of this treatment. I have reviewed and completely understand all of the benefits and contraindication including this form.

Signature: _____ Date: _____