CONSENT & CONTRAINDICATION FORM

I understand that the TheraLight 360 Full Body Photobiomodulation System is a safe and non-invasive treatment and has been cleared by the FDA to emit photon energy for the relief of minor muscle and joint pain, muscle spasm, pain and stiffness associated with minor arthritis, promoting relaxation of muscle tissue and temporary increase in local blood circulation. I understand that every individual responds uniquely to light therapy treatments. Some patients may see immediate results or may require several treatments before they begin to feel results. Note: Occasionally some clients may experience mild fatigue, discomfort or aches after their first treatment. This is a normal healing phenomenon known as retracing. These responses should reduce after 24-48 hours, if they persist notify the technician prior to your next appointment.

CONTRAINDICATIONS

YES NO Are you pregnant?
More research is necessary to detect any potential adverse effects of PBM during pregnancy before PBM Therapy can be utilized while pregnant.

YES NO Do you have cancer?
More research is necessary to detect any potential adverse effects of PBM on cancer treatment outcomes before PBM Therapy can be utilized in clients with active cancer diagnosis.

YES NO Are you taking immune suppressant medications as a result of receiving an organ transplant?
More research is necessary to detect any potential adverse effects of PBM on patients taking immune suppressant medications before PBM Therapy can be utilized by these clients.

YES NO Have you ever had an Aneurysm?

YES NO Do you have an Embolization in your body or brain?

PRECAUTIONS:

YES NO Have you had steroid injection(s) within the past 7 days?
This does not include topical or oral medications.

YES NO Do you have Open Wounds or Skin Lesions?
You must inform your technician, prior to treatment, if you have any recent open wounds or skin lesions. For the protection of all TheraLight 360 users, all lesions must be covered with an appropriate dressing/bandages.

YES NO Are you over 18?
A person who is less than (18) years of age may not use TheraLight 360 without written parental/guardian consent

YES NO Are you currently taking photosensitizing medications?

YES NO NA If yes, can you be in the sun for 10 min. without having itchiness, redness, blotchiness or pigmentation issues?

YES NO Do you have a seizure disorder?
In a small percentage of persons with seizure disorders, exposure to flashing lights at certain intensities or to certain visual patterns can trigger seizures. As such, we recommend you do not use under the 100Hz pulse setting AND use black out goggles or a blackout eye pillow while using the TheraLight 360 Full Body System.

YES NO Do you have Electrical Sensitivity, also known as Electrical Oversensitivity (EO), electromagnetic stress, or Electrical Hypersensitivity (EH or EHS)?

ACKNOWLEDGEMENT

I have read and understand the foregoing: I understand the TheraLight 360 Full Body Photobiomodulation System treatment I receive today is of my own choosing. This Therapy Consent Form applies to subsequent visits and treatments. I understand that there are no promises or guarantees regarding the results of the treatment and that to achieve maximum clinical results, I may need multiple treatments.

WAIVER OF LIABILITY, ASSUMPTION OF RISK AND HOLD HARMLESS AGREEMENT:

I hereby release, acquit, and forever discharge and hold harmless this business, and their past, present and future officers, directors, stockholders, attorneys, agents, servants, representatives, employees, corporations, subsidiaries, affiliates, partners and partnerships, insureds, predecessors and successors-in-interest and all other persons or entities for whose conduct it may be liable, of and from any and all claims, demands, damages, causes of action, suits and liabilities, which may arise, known or unknown, now have or which may hereafter accrue, because of, arising out of or in any way connected with the services received from this business or their employees or agents.

Patient Signature	Guardian Signature	Date:
Please Print Patient Name	Please Print Guardian Name	Date: