



LED Light Therapy Informed Consent, Side Effects, and Treatment Authorization

Purpose of LED Light Therapy

LED (Light Emitting Diode) Light Therapy is a non-invasive therapy that uses specific wavelengths of light on the face, scalp/head, or body to support overall wellness and tissue function. Depending on the treatment goals, LED Light Therapy may be used to help support:

- Skin appearance and texture
- Circulation and lymphatic flow
- Relaxation and stress reduction
- Muscle and joint comfort
- Scalp and hair wellness
- Temporary reduction of inflammation
- Tissue recovery and healing support

Results vary from person to person, and no guarantees have been made regarding the outcome of treatment.

Informed Consent

I understand the following:

1. LED Light Therapy is considered a supportive wellness modality and is not intended to diagnose, treat, cure, or prevent any disease.
2. The practitioner has discussed the nature and purpose of LED Light Therapy with me, including the potential benefits, possible side effects, and alternatives.
3. I understand that individual responses to treatment may vary.
4. I understand that multiple sessions may be recommended depending on my condition, goals, and response to therapy.
5. I understand that I may stop treatment at any time and may ask questions regarding the procedure before or during treatment.
6. I understand that protective eyewear may be required during treatment depending on the treatment area and type of light being used.
7. I understand that I should inform the practitioner if I am pregnant, suspect pregnancy, have epilepsy or seizure disorders, light sensitivity, active cancer, autoimmune conditions, open wounds, recent surgery, skin disorders, or if I am taking medications or supplements that may increase light sensitivity.
8. I understand that I should inform the practitioner if I have recently used photosensitizing products, chemical peels, retinoids, tanning products, or had excessive sun exposure.

Possible Side Effects and Risks



Although LED Light Therapy is generally well tolerated and non-invasive, possible side effects and reactions may include:

- Temporary redness or warmth
- Mild skin irritation or dryness
- Temporary tightness or sensitivity of the skin
- Headache or eye strain
- Fatigue or temporary increase in symptoms
- Dizziness or lightheadedness
- Tingling sensations
- Temporary breakouts or skin purging
- Temporary scalp sensitivity
- Rare allergic or sensitivity reactions

I understand that unforeseen side effects or reactions may occur.

Contraindications and Precautions

I understand that LED Light Therapy may not be appropriate for certain individuals or conditions. I agree to inform the practitioner if I:

- Have epilepsy or a seizure disorder
 - Have a history of light-triggered migraines
 - Have photosensitivity or sensitivity to light
 - Am taking medications that increase photosensitivity
 - Have active skin infections or open lesions
 - Have active cancer unless approved by my physician
 - Am pregnant or breastfeeding
 - Have recently had cosmetic procedures, surgery, or injections
 - Have implanted electronic devices unless cleared by my physician
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Treatment Authorization and Release

I voluntarily consent to receive LED Light Therapy treatments on my face, scalp/head, and/or body.

I acknowledge that no guarantees or assurances have been made regarding the results of treatment.

I understand that LED Light Therapy is elective and that I am responsible for communicating any discomfort, reactions, medical conditions, medication changes, or concerns to the practitioner.



I release and hold harmless the practitioner, clinic, employees, and affiliates from any liability associated with treatment, except in cases of gross negligence or misconduct.

I certify that I have read and understood this form and have had the opportunity to ask questions before signing.

Consent

Treatment Areas Authorized (check all that apply):

- Face
- Scalp/Head
- Neck
- Back
- Arms
- Legs
- Other: _____

Patient Signature: _____

Date: _____

Practitioner Signature: _____

Date: _____

By signing and printing, I understand all the above and have had a chance to ask any questions that I have prior to starting treatment:

Signature

Print

Today's Date