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RED LIGHT BED/LED FACIAL LIGHT AGREEMENT AND CONSENT FORM

Client Information

Name (First and Last): _____
DOB: _____

Email
(Optional)_____

Please read, understand, and initial the following:

- ☐ 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, make-up, fragrances, oils, and lotions. Remove jewelry.
- ☐ Certain medications or cosmetics may increase your sensitivity to the red and/or LED light

Are you/do you currently take any of the following (please circle all the apply):

Pregnant/Breastfeeding:	YES	NO	Active Bleeding:	YES	NO
Low Blood Pressure:	YES	NO	Infectious Diseases:	YES	NO
Epilepsy/Seizures:	YES	NO	Sensitivity to Light:	YES	NO
Active Carcinoma:	YES	NO	Taking Blood Thinners:	YES	NO
Malignant Tissue:	YES	NO	Taking Nitrates:	YES	NO
Hemorrhaging:	YES	NO	Undergoing Chemotherapy	YES	NO

**If you answered yes to any of the above, we suggest consulting your physician prior to using LED light therapy.*

- For optimal results recommended therapy schedules are 3-4 days per week, for 4-6weeks. After the initial treatment schedule, it is recommended to continue 1-2 days per week.
- After treatments sit up slowly to prevent dizziness. I understand that LED 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 LED Light Therapy. I acknowledge that the results of LED light therapy do vary, and that no guarantees of specific results are offered or implied. Oswell Chiropractic Centre 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 of 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. I have reviewed and completely understand all of the information.

Signature: _____

Date: _____

If the clients under 18 years of age: As parent\ legal guardian of the above listed client, I acknowledge that I have read and understood the safety standards and warnings provided to me by Oswell Chiropractic Centre and thereby authorize the consumer named above to use red light\ led light therapy. I acknowledge that I have read and completely understand this consent form, and agree to the above waivers of liability, recommendations and terms. I attest that I have provided accurate age, identity and relationship verification.

Parent/Guardian Signature: _____

Date: _____