

Low-Level Light Therapy Informed Consent Form

INSTRUCTIONS: This is an informed consent document that has been prepared to help your healthcare provider inform you concerning low-level light therapy treatments, the potential risks involved and result expectations. Please be advised that this is not a surgical procedure. It is important that you read this information carefully and completely and sign the consent for LED treatments, as proposed by your healthcare provider, acknowledging that you have read and understand the nature of the treatments and consent to receiving such treatments.

INTRODUCTION: Originally researched and developed by NASA, low-level light therapy, also known as photobiostimulation, is the application of light energy to the body to obtain therapeutic benefits. It produces a natural photobiochemical reaction similar to the process of plant photosynthesis, and has a wide range of beneficial applications across many medical fields, including the treatment of skin, muscle, joint and pain conditions. Low-level light therapy provides compromised cells with the energy to regain and restore vitality naturally. Its powerful, deeply penetrating wavelengths are absorbed by photoacceptors in the mitochondria of cells. This process increases the production of adenosine triphosphate (ATP), the fuel that drives all cells. This boost of cellular energy results in a cascade of metabolic events leading to an increase in microcirculation, tissue repair, and a decrease in inflammation and pain.

PROCEDURE: Unless modified by your healthcare practitioner, treatment sessions consist, each, of 30-minute increments. The total amount, and frequency, of visits within a course of treatments will depend on the condition(s) treated and their severity. This will be determined at the time of the initial consultation. Should additional treatments augment the desired results, the practitioner will discuss them with you.

BENEFITS: Low-level light therapy has been shown to effectively treat a wide variety of skin and musculoskeletal conditions. It is FDA-cleared for wrinkles and acne as well as arthritic pain, muscle and joint pain, and muscle and joint stiffness. In addition, it has clearances for muscle tissue tension and spasm, and is proven to decrease inflammation and increase microcirculation and can be used anywhere on the body.

CONTRAINDICATIONS: Not for use on children under 12; do not use over breast or stomach of breast feeding or pregnant woman; patients with epilepsy or history of seizures; avoid with patients taking cortisone or other steroidal injections; avoid patients taking photosensitive drugs; do not use over known cancer tumor or metastasis; eye protection recommended but not required.

DISCLAIMER: Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your healthcare provider may provide you with additional or different information, which is based upon all the facts in your particular case and present state of knowledge within this field. It is important that you read the above information carefully and have all of your questions answered before signing the following consent.

CONSENT FOR FACIAL LOW LEVEL LIGHT THERAPY TREATMENT

1. I hereby authorize EASTERN MEDICAL HEALTH GROUP, it's assigned practitioners, and such assistants as may be selected to perform low-level light therapy treatments. I have received the LOW-LEVEL LIGHT THERAPY INFORMED CONSENT FORM.
2. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained
3. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
 - A. THE ABOVE TREATMENT OR EXPOSURE TO BE UNDERTAKEN
 - B. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
 - C. ANY POSSIBLE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-3). I AM SATISFIED WITH THE EXPLANATION

Patient (or Person Authorized to Sign for Patient)

Authorized signature for Eastern Medical Health Group

Date

Date