

# Light Therapy Waiver & Informed Consent

I understand that attending demonstrators are not licensed physicians and are unable to cure, diagnose, mitigate, prevent, or treat conditions. Services provided by the demonstrator are for pain reduction and increased circulation. Light therapy should not be used as a replacement for medical treatment from a licensed physician or other healthcare provider. I have been informed that light therapy is generally safe. While side effects are not common, if they do occur, they're usually mild and short lasting. They may include:

*Increased sensation, itching, or pain to the treated area due to increased circulation*

*Elevated temperature, skin irritation or uncomfortable warmth on the treated area due to increased circulation*  
*Eyestrain / Headache*

LED light therapy is the process in which certain colors of light are used to trigger naturally occurring physiological processes in the body, including cellular healing and nitric oxide release. Clinical studies show nitric oxide can help increase and support basic functions in nearly every part of the body including, but not limited to, increased circulation, stimulated collagen production, increased lymphatic system activity, and decreased nervous excitability. LED light therapy is non-invasive, non-abrasive, and safe for all ages.

***For the diagnosis and treatment of any disease, consult a licensed Physician.***

**Are you/do you currently take any of the following (Please circle all that 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 item, you must get approval from a licensed physician prior to demonstration or use of the device.*

No client information will be disclosed to anyone outside of the demonstration without written consent from the client, unless required by law.

This agreement is made upon the express condition that the demonstrator and device manufacturer shall be free from all liabilities and claims for damages and/or suits for or by reason of any injury, or death to any person or property of the client while in or upon said premises of services given or any part thereof during sessions of this agreement in connection herewith, and the client hereby agrees to hold harmless the demonstrator and device manufacturer from all liabilities, charges, expenses and costs on account of or by reason of any such injuries, deaths, liabilities, claims, suits, damages, or losses however occurring out of each session.

By signing below, I agree that information I have provided is accurate to the best of my knowledge. I have read and understand all above information, and give my full consent to receive light therapy from the demonstrator. I acknowledge that this consent is given of my own free will and conscience, with no outside sources affecting my decisions, and that any questions have been answered by the demonstrator.

Print Name:

Date:

Home Number:

Mobile Number:

Email:

Client Signature:



**In Light**  
WELLNESS SYSTEMS

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# Client Feed Back

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please comment on your results of the light energy session. I feel:

- Relaxed  Yes  No  
Less pain  Yes  No  
Symptoms have shifted  Yes  No  
Energized  Yes  No  
Lighter  Yes  No  
Happier  Yes  No

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## Please check all that apply:

I would like to learn more about light energy:

- Yes  No

I value light therapy. I am interested in receiving a follow up session:

- Yes  No

Location/City:

I have a friend or family member who would benefit from light energy. Please provide me with a referral practitioner for this person.

- Yes  No

I love the idea of helping light up the world. I would like to participate in the following:

Introduce others to light energy: \_\_\_\_\_

Host a presentation at my:  home  office

Thank you



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