# CELLUMA

# LIGHT THERAPY SESSIONS CONSENT FORM

| | | | | |
|---|---|---|---|---|
| Your Name: | Referred by: | | Today's Date: | |
| Address: | City: | State: | Zip: | |
| Home #: | Work #: | Cell #: | | |
| Email Address: | | | | |
| Height: | Weight: | Date of Birth: | Age: | Sex: |

Are you currently under the care of a physician? ❑ No ❑ Yes, for what reason(s):

Have you ever had cancer? ❑ No ❑ Yes, explain:
(We cannot place LED therapy over known metastasis.)

Do you have a seizure disorder? ❑ No ❑ Yes (Requires PCP Approval)

Do you have sensitivity to heat or increased warmth in the area of skin you are treating? ❑ No ❑ Yes
(Resistors on the circuit board produce a mild thermal effect.)

Are you "photo-sensitive"? ❑ No ❑ Yes
Some disorders and medications can cause photosensitivity. (Requires PCP Approval)

**Cautions with medications because of light sensitivity:**

- The following medicines are known to cause temporary photosensitivity:
- Chlorpromazine (Anti-psychotic), also know as Thorazine, Chlorpromazine HcL, Sonazine.
  Client can be treated if the medication has not been taken within the last 8 days.
- Griseofulvin (Anti-Fungal), also known as Grifulvin V, Fulvicin P/G, Gris-Peg.
  Client can be treated if the medication has not been taken within the last five days.
- Isotretinoin (Anti-Acne), also know as Accutane.
  The client can be treated if the medication has not been taken within the last six months.
- Tetracycline's (antibiotic) also known as Helidac, Terra-Cortril, Terramycin, Sumycin, Tetracycline HcL, Bristacycline, Achromycin V, Actisite, Tetrex, Doxycycline, Ciprofloxacin.
  Client can be treated if the medication has not been taken within the last five days.
- Methotrexate (Anti-Arthritis & Anti-Cancer), also known as Methotrexate Sodium, PF & LPF, Mexate-AQ, Folex, Trexall.
  Client can be treated if the medicine has not been taken within the last three days.
- Amiodarone (Anti-Arrythmic), also known as Amiodarone Codarone x, Pacerone.
  Treatment can be administered at the physician's discretion.

Are you currently taking any steroidal medications? ❑ No ❑ Yes (Cannot be treated with LED therapy.)

Do you exercise? ❑ No ❑ Yes, how often? What type?

Which do you want us to focus on? ❑ Anti-Aging ❑ Acne ❑ Pain

** If you checked pain, please expand on history and type of pain:

Are you unhappy with your skin tone? ❑ No ❑ Yes (If Yes, what is your concern and where: _____)

## Light Sensitive Contraindications

Please initial if you DO NOT have the following Light Sensitive Contraindications:
___Chlorpromazine (Anti-psychotic), also known as Thorazine, Chlorpromazine HcL, Sonazine. You can be treated if the medication has not been taken within the last eight days.
___ Griseofulvin (Anti-Fungal), also known as Grifulvin V, Fulvicin P/G, Gris-Peg.
You can be treated if the medication has not been taken within the last five days.
___Isotretinoin (Anti-Acne), also known as Accutane.
You can be treated if the medication has not been taken within the last six months.
___Tetracycline's (Antibiotic) also known as Retin-A, Renova, Atralin, among others.
You can be treated if Tretinoin is used only at night.
___Methotrexate (Anti-Arthritis & Anti-Cancer), also known as Methotrexate Sodium, PF & LPF, MexateAQ, Folex, Trexall.
You can be treated if the medication has not been taken within the last three days.
___Amiodarone (Anti-Arrythmic), also known as Amiodarone Codarone x, Pacerone.
Treatment can be administered only with your physician's written permission.
__Any herbal supplements such as St. John Warts. LIST HERE: _____

**Please initial the following statements:**
___ I have read all the pre-care instructions on the Brickhouse Day Spa's website to prep for my LED therapy session.
___ I have done my research and/or discussed LED-Light therapy with my physician and understand the treatment and risks.
___ I understand there are other precautions that should be considered before receiving LED therapy treatments and may require a doctor's release and/or I assume any risk involved.
___ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.
I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.
___ I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.
___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.
___ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

I, _____, hereby give my consent and voluntary release to the Brickhouse Day Spa, LLC from any claims, implied or stated that I have or may have in the future with this treatment, regardless of result. I certify that I have read and fully understand the possibility of known and unknown risks, complications and limitations to this procedure. I agree that this constitutes my full disclosure of my medical and health background.

1. The nature and purpose of the treatment has been explained to me, and any questions I have regarding this treatment have been explained to my satisfaction. _____ (initial)
2. I understand that with any treatment, certain risks are involved and that any complications or side effects from unknown causes could occur. I freely assume these risks. _____(initial)
3. I understand that the LED light procedure should not be administered to people with the following conditions and I do not have any of these conditions. _____(initial)

- Persons diagnosed with basil cell carcinoma
- Pregnancy
- Epilepsy
- Taking medications that cause sensitivity to light (example: tetracycline)
- Broken or inflamed areas of skin
- Botox or cosmetic fillers (must wait a min of 5-days post treatment)

I give permission to the Brickhouse Day Spa LLC staff to perform the LED procedure discussed.

Signature: _____ Date: _____