



## LED Light Therapy Consent Form

### Client Information:

- **Name:** \_\_\_\_\_
- **Date of Birth:** \_\_\_\_\_
- **Phone & email:** \_\_\_\_\_

### Medical History:

Please indicate if you have any of the following conditions (check all that apply):

- Pregnant or breastfeeding
- History of epilepsy or seizures
- Currently taking photosensitizing medications (e.g., certain antibiotics like Tetracycline)
- Diagnosed with photosensitive disorders
- Active cancerous tumors or metastasis
- Recent cortisone or steroid injections (within the past few days)
- Other medical conditions: \_\_\_\_\_

### Consent & Release of Liability:

I, \_\_\_\_\_ (client's name), confirm that I have provided accurate and complete medical information. I understand that **LED Light Therapy is a non-invasive treatment** and does not diagnose, treat, or cure any medical conditions.

I acknowledge that I have been informed of the potential risks, contraindications, and precautions associated with LED Light Therapy. I agree to proceed with the treatment at my own discretion.

I understand that **Sage Wellness Spa, its employees, and independent contractors are not responsible for any adverse reactions, injuries, or complications that may arise as a result of this treatment.** I release **Sage Wellness Spa, its employees, and contractors from any liability** related to LED Light Therapy.

I have had the opportunity to ask questions and understand that I may withdraw my consent at any time.

**Client Signature:** \_\_\_\_\_

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