Key Therapeutics, LLC: Red Light and Near Infrared Therapy Screening & Consent Form

Patient Name: _____ DOB: _____ Date: _____

☐ I acknowledge and agree to an additional fee of $25 for each 20-minute Red Light and Near Infrared (NIR) Therapy session.

Medical Screening: Please check all that apply.

Medical Conditions/History

☐ Pregnant or may be pregnant
☐ Active cancer/undergoing cancer treatment
☐ Photosensitivity disorder (lupus, porphyria, etc.)
☐ History of light-induced seizures/epilepsy
☐ Active infection or fever
☐ Active bleeding disorder
☐ History of DVT or active blood clot

Other Precautions

☐ Taking medications that increase light sensitivity* see below *
☐ Recent eye surgery (within 6 months)
☐ Severe eye disease
☐ Organ transplant recipient
☐ Hyperthyroidism/thyroid disorder
☐ Pre-existing hyperpigmentation (contraindicated under clinic protocol)
☐ None of the above

If you have checked YES to any of the above, please discuss with Key Therapeutics, LLC before scheduling an appointment.

WARNING: Certain antibiotics, antifungals, acne medications, antidepressants, antipsychotics, amiodarone, St. John's Wort, and some chemotherapy medications may increase sensitivity to light and the risk of skin or eye irritation. If you are taking any of these medications or supplements, please defer treatment and consult with your physician.

Please list any medications, supplements, or medical concerns not listed above: _____

Patient Acknowledgment

I understand that:

1. Red Light and Near Infrared (NIR) Therapy are adjunctive therapeutic and wellness modalities that may be used as a complement to my treatment.

2. Individual responses vary, and no guarantees regarding treatment outcomes have been made.

3. I have disclosed all known medical conditions, medications, supplements, and relevant medical history.

4. I understand that physician clearance may be recommended or required based on certain medical conditions, medications, or medical history.

5. I may discontinue Red Light and Near Infrared (NIR) Therapy at any time.

6. I agree to notify Key Therapeutics, LLC immediately if I experience discomfort or adverse symptoms during or following treatment.

Eye & Exposure Safety

Please initial each statement:

_____ I understand that I must not look directly into the treatment lights.

_____ I understand that protective eyewear is REQUIRED AT ALL TIMES when the treatment lights are on.

_____ I agree to immediately report any visual changes, eye discomfort, headache, or other concerning symptoms.

_____ I understand that the treatment lights must remain **at least 8 inches from my body and face.**

_____ I understand that excessive exposure to the body or face may cause unwanted skin changes, including pigmentation changes. The risk of photoaging from excessive red/NIR exposure is not established. **I agree to follow the recommended instructions to avoid overexposure.**

Possible Side Effects After your session, please stay hydrated.

Possible temporary side effects may include: Mild warmth or redness of the skin; temporary increase in symptoms; headache; dizziness or lightheadedness; eye discomfort if safety instructions are not followed; temporary fatigue.

Treatment Sensations & Safety

Gentle warmth during and after treatment is normal. Over time, you may experience increased muscle relaxation, reduced stiffness, reduced inflammation and pain relief. Individual results vary.

If you experience discomfort, excessive heat or sensitivity, stop exposure immediately. Increase the distance from the lights or reduce exposure time before resuming only if symptoms resolve; discontinue use if discomfort persists.

Consent for Red Light and Near Infrared (NIR) Therapy

I have had the opportunity to ask questions regarding Red Light and Near Infrared (NIR) Therapy, and my questions have been answered to my satisfaction. I voluntarily consent to receive Red Light and Near Infrared (NIR) Therapy.

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____