HEALTHY BODY HEALTHY SOUL

RED LIGHT THERAPY BED (RLTB) INFORMED CONSENT AND WAIVER (version 12/26/25)

Member Name:_____

ACKNOWLEDGEMENT OF RISKS: Please initial in the spaces provided:

1. _____ I am 18 years of age or older, OR I am the parent consenting to the use of the RLTB by this minor child.
2. _____ I understand that the use of the RLTB may involve risks, including but not limited to temporary skin irritation, burns, photosensitivity reactions, or eye injury if precautions are not followed.
3. _____ I understand that Red Light Therapy is not intended to diagnose, treat, cure or prevent any medical condition and that results vary by individual. I agree to consult my healthcare provider prior to using the RLTB if I have any medical condition (including but not limited to: active skin or soft tissue malignancy, epilepsy, hyperthyroidism, Lupus, porphyria), am pregnant, sensitive to light, or on medications that may increase light sensitivity.
4. _____ I understand that in consideration of being allowed to use the Red Light Therapy Bed, Member agrees to indemnify, release and hold harmless, Healthy Body Healthy Soul (HBHS) and its owners, staff and agents from any adverse event resulting from use of the RLTB, and from any and all claims, demands, actions, or causes of action arising from injury, loss or damage sustained during or as a result of my use of the RLTB, whether caused by negligence or otherwise. I voluntarily choose to participate in services including red/near infrared light therapy and accept full responsibility for any risks or consequences and can discontinue use at any time.
5. _____ I understand and agree to follow all of the procedures established by HBHS for use of the RLTB for <u>every</u> RLTB session I participate in, including but not limited to the following:
    a. Notify us if you are taking any medications that can cause photosensitivity reactions (including but not limited to: tetracycline, sulfa or quinolone[floxin] antibiotics, retinoids such as Accutane, lithium or other medications deemed by your healthcare provider or pharmacist to increase your risk of rash when exposed to Red Light or Near Infrared Light).
    b. Keep covered and not expose to the RLTB any actively infected or unhealed wound
    c. Keep covered and not expose any active cancerous lesion of the skin or soft tissue
    d. Wear protective goggles at all times that the Red Light is activated
    e. Obtain clearance from Eye medical provider before using RLTB if I am under treatment for eye conditions such as glaucoma, cataracts or recent eye surgery, and obtain clearance from provider(s) who inserted any electronic medical device into my body (ie pacemaker).
6. _____ I have had enough time to consider the above information and feel that I am sufficiently advised to fully consent to this therapy service. I have had an opportunity to ask questions and am fully aware of what I am signing and am consenting to this therapy on my own free will.

Member/Parent Signature: _____Date: _____