Red light therapy consent form

Consent to red light therapy sessions

I voluntarily request and consent to red light therapy, LED light therapy or other photobiomodulation sessions provided by **[Business Name]**.

Sessions may include:

- Full-body red light or near-infrared beds and pods
- Standing or wall-mounted light panels
- LED facial masks and handheld devices
- Light sessions combined with other wellness, spa or fitness services

I understand that participation is voluntary and that I may end a session at any time.

[Business Name] may refuse, adjust or end a session if it reasonably believes the session is not suitable for me or if I do not follow instructions.

Not a medical treatment

I understand that red light therapy provided by **[Business Name]** is offered as a wellness or cosmetic service. It is not a substitute for medical diagnosis, treatment or advice.

Staff are not providing medical advice, and they do not diagnose, treat or cure any medical condition.

I understand that individual responses vary and that **[Business Name]** does not guarantee any particular result, including results relating to skin appearance, recovery, pain, sleep, mood or performance.

I will continue to follow any treatment plan from my own healthcare provider and will consult them if I am unsure whether light therapy is appropriate for me.

Health screening and contraindications

I confirm that I have told **[Business Name]** about any of the following that apply to me:

- Medications or supplements that can increase sensitivity to light, such as certain antibiotics, acne medications, diuretics, retinoids or herbal products
- Photosensitivity conditions or a history of abnormal reactions to light
- Lupus, porphyria or another condition that may be affected by light exposure
- Pregnancy or possible pregnancy

- Epilepsy, seizures or sensitivity to bright or flashing light
- Migraines triggered by light
- Current cancer, cancer treatment or a history of skin cancer
- Eye conditions, recent eye surgery or medications affecting the eyes
- Recent cosmetic procedures, injectables, chemical peels or laser treatments in the treatment area
- Thyroid conditions, where a session would expose the neck area
- Implanted medical devices, or any other medical condition that may be relevant

I understand that some of these may mean light therapy is not suitable for me, or that I should obtain clearance from a healthcare provider before my first session.

I will tell staff before each session if my health, pregnancy status or medications change.

Eye protection

I understand that red and near-infrared light devices can be very bright and that looking directly at the light may cause eye discomfort or strain.

I agree to:

- Wear the eye protection provided or recommended for the device
- Keep my eyes closed where instructed, including when using an LED facial mask
- Not look directly into the light source
- Tell staff immediately if I notice eye pain, blurred vision or persistent visual disturbance

---

Session duration and use of equipment

I agree to follow the session time, distance from the device and frequency recommended by **[Business Name]** and the equipment manufacturer.

I will not increase the session time, repeat sessions back to back or adjust the device settings without staff permission.

I agree to use beds, panels and masks only as instructed, to enter and exit equipment carefully, and to report any equipment that appears damaged, unusually hot or faulty.

Possible effects

I understand that red light therapy is generally well tolerated, but that some people may experience:

- Warmth of the skin during or after a session
- Temporary redness or skin sensitivity
- Eye strain, glare or discomfort
- Headache or light-headedness
- Dryness or irritation of the skin
- Discomfort from heat or from lying still in an enclosed bed
- Rarely, a burn or reaction where the skin is sensitive, a photosensitising substance is present or instructions are not followed

I will stop my session and tell staff if I feel unwell, overheated, dizzy, have a headache or notice burning, blistering or unusual skin changes.

Skin preparation

I understand that skincare products, make-up, perfume and some topical treatments may affect how my skin responds to light.

I agree to follow any instructions to remove make-up or products from the treatment area and to tell staff about any topical medications or active skincare I am using.

Hygiene and shared equipment

[Business Name] will clean shared surfaces and equipment between clients in line with its hygiene procedures.

I agree to follow facility rules on towels, clothing and cleaning, and to tell staff if I have a contagious skin condition, open wounds or infection that could affect other clients.

I will not use a facial mask or device on broken or infected skin unless staff confirm it is appropriate.

Photographs and progress records

I understand that **[Business Name]** may offer to take before and after photographs to track my progress.

Photographs will be taken only with my consent and will not be used for marketing unless I give separate consent.

Payments, memberships and refunds

I understand that sessions, packages and memberships are subject to the pricing, cancellation and refund policies of **[Business Name]**.

Because results vary between individuals, refunds are not given solely because I did not achieve a particular result, except where applicable consumer law requires otherwise.

Assumption of risk

I knowingly and voluntarily accept the ordinary risks associated with red light therapy sessions.

I accept responsibility for reactions, injuries or losses caused or materially contributed to by:

- Health information, medications or pregnancy status I concealed or provided inaccurately
- A contraindication I did not disclose
- My failure to wear eye protection or follow session instructions
- Exceeding the recommended session time or frequency
- Using the equipment in a way that staff did not authorise

Liability release

To the fullest extent permitted by applicable law, I release **[Business Name]** and its owners, staff, employees, contractors and representatives from claims arising solely from:

- The ordinary risks of red light therapy knowingly accepted in this form
- Information I concealed or provided inaccurately
- My failure to follow reasonable instructions or facility rules
- Individual variation in response or the absence of a particular result

This release does not exclude or limit liability that cannot legally be excluded or limited.

It does not apply to fraud, intentional misconduct, gross negligence, faulty equipment caused by the business's failure to maintain it, violations of mandatory consumer rights or any other liability that applicable law prohibits the business from waiving.

Privacy and recordkeeping

I understand that **[Business Name]** may collect and retain information where reasonably necessary to:

- Manage bookings, memberships and client records
- Screen for contraindications and record relevant health information
- Record sessions, devices used and session times
- Respond to reactions, complaints or legal claims
- Meet insurance and legal obligations

Information will be handled according to the business's privacy notice and applicable data-protection laws.

Final declaration

By completing and signing this form, I confirm that:

- I have read and understood the entire form.
- The information I have provided is complete and accurate.
- I have disclosed any medications, conditions or pregnancy that may affect my suitability.
- I understand that red light therapy is not a medical treatment and that results are not guaranteed.
- I will wear eye protection and follow session times and instructions.
- I will stop and tell staff if I feel unwell or notice any unusual reaction.
- I had an opportunity to ask questions before signing.
- I understand that this form does not remove rights or protections that cannot legally be waived.

Client completion

Contact details

First name *

Last name *

Phone

Email *

Date of birth

Session type

- [ ] Full-body bed or pod
- [ ] Light panel
- [ ] LED facial mask
- [ ] Other device

Do any of the following apply to you? *

- [ ] Taking photosensitising medication or supplements
- [ ] Photosensitivity condition
- [ ] Pregnant or possibly pregnant
- [ ] Epilepsy or sensitivity to bright light
- [ ] Current or past cancer
- [ ] Eye condition or recent eye surgery
- [ ] Recent cosmetic procedure in the treatment area
- [ ] None of these

Please give details of any conditions, medications or previous reactions to light

- [ ] I have read, understood and agree to the Red Light Therapy Consent Form above. I confirm that the information I have provided is accurate and that I voluntarily consent to red light therapy sessions and accept their risks. *

Signature *