AFFINITY
ACUPUNCTURE
& ROLFING

Basic Consent for LIGHTWAVE™Therapy

You have chosen, after consultation with your doctor/esthetician, to undergo LIGHTWAVE Therapy. The purpose of this treatment is for:

Items to consider before LIGHTWAVE™ Therapy:

1. It is important to tell staff if you are pregnant, diabetic, taking antibiotics, or have cancer.
2. The final results may not be apparent for several weeks after the treatments.
3. Sun bathing, alcohol consumption, smoking and eating habits directly affect outcome of the treatment. Remember to eat well and limit sun bathing, alcohol and smoking to a minimum.
4. Drink at least 8oz of water before and after the treatment.
5. Do not apply creams, moisturizers or antiperspirants before a treatment.
6. It is important to notify the clinic if there are any problems or concerns after the treatment, including prolonged redness.
7. The fee is paid for the treatment itself. There is no guarantee that the expected or anticipated results will be achieved.
8. More than one treatment package may be required. There will be a charge for each additional treatment.

I have fully explained to the patient_____the nature, purpose and expected results of LIGHTWAVE™ Therapy, the risks and consequences that are involved and alternative treatments. I have answered all questions regarding the treatment. Written information, when available, has been provided.

Physician/Esthetician Date: _____

My signature verifies that I have read and understand the goals, limitations, risks, and possible side-effects to the treatment, and that I have been given the opportunity to ask questions. My signature also verifies my informed decision to proceed with LIGHTWAVE™ Therapy and have the treatment. I additionally consent to the taking of photographs during the course of my LIGHTWAVE™ Therapy for the purpose of medical education.

Patient Signature (or legal guardian): _____Date: _____