THE

GOODFACE

Light-Emitting Diode (LED) Therapy Consent Form

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your LED treatment, please be aware of the following information and possible risks. Please initial:

____ I understand there are certain contraindications that would preclude me from receiving LED treatments, including epilepsy, medications causing light sensitivity, open wounds, pregnancy, and thyroid conditions.

____ I understand there are other precautions that should be considered before receiving LED therapy treatments and may require a doctor's release and/or I assume any risk involved.

____ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

____ I understand that some clients report slight tingling sensations and flashing of the optic nerve during the procedure.

____ I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

____ I undertand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.

____ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

____ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

____ I consent to "before and after" photographs for the purpose of documentation, potential advertising and promotional purposes.

I understand that if I have concerns, I will address these with my skin therapist. I give permission to my skin care therapist to perform the LED procedure we have discussed, and will hold him/her and The Goodface harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my skin care therapist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care therapist immediately. I agree that thiis constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully undrerstand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skin care therapist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client Name (printed): _____

Client Signature: _____Date:_____

Technician: _____Date:_____