Grand Rapids Natural Health, LLC
ENERGY & LIGHTS, LLC
Mary Wisniewski, Physician Assistant
Certified Light Therapist & Educator
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LED LIGHT ENERGY THERAPY INFORMED CONSENT

Date: _____

Name: (Print) _____ID_____

Address: _____City: _____

State: _____ Zip: _____ Cell Phone: _____ Home Phone: _____

Email: _____ Referred by: _____

Credentials: I understand that Mary Wisniewski is a Certified Light Therapist providing LED (Light Emitting Diode) light therapy services and is not a medical doctor.

Disclaimer: I understand that Mary Wisniewski is not a licensed physician and is not licensed to diagnose or treat specific diseases. If a medical diagnosis or treatment is required, it must be obtained from a licensed physician.

Notice: I do understand that Mary Wisniewski, PA doing business as Energy & Lights, LLC is a separate entity from Grand Rapids Natural Health, LLC and conduct separate practices from each other. Mary Wisniewski, PA rents office space from Grand Rapids Natural Health, LLC. Grand Rapids Natural Health, LLC exercises no control over the practice of Mary Wisniewski, PA. I will not hold Grand Rapids Natural Health, LLC responsible for any actions or inactions of Mary Wisniewski, PA.

Scope of Practice: Light therapy is a process whereby the device emits a bandwidth of low level pulsed light frequencies to certain parts of the body thereby helping repair damaged cells. Light emission must be absorbed to produce biological responses such as pain reduction and increased circulation. I understand that light therapy is only being utilized for pain reduction and increasing localized circulation, as per the device's FDA clearance. It is not intended to treat or cure any disease.

Permissions:

1. I acknowledge that at times the Therapist will need to professionally and appropriately help me [client] to apply the light pads to my body. I give permission for "**hands-on-my-body**" assistance. **Initials**: _____
2. I am aware that at times improved circulation may result in **a temporary increase in pain/discomfort.** I give permission **to proceed forward** with the Light Therapy treatment. **Initial: _____**
3. I am aware that at times **an assistant** to the Therapist will be asked to apply the light pads on me. I give permission for the assistant to apply the Light Pads and view the information in my file to assure Effective continuation of Light Therapy. **Initial _____**
4. Client feedback regarding symptoms, severity/improvement, location of pain/discomfort and quality of life issues will be helpful. I acknowledge that **feedback is voluntary and welcomed**. **Initials**: _____

Benefits of Light Therapy: The expected benefits from undergoing light therapy for areas upon which Low Level Pulsed LED Light pads are placed include pain reduction and a localized increase in circulation

Contraindications: Light therapy is non-invasive. It is important to notify the therapist if your medical history changes such as becoming pregnant or if you have been diagnosed with an unexpected medical condition.

Please answer the following questions: Do you have any of the following conditions?

☐ Yes | ☐ No Do you have chronic low blood pressure?
☐ Yes | ☐ No Do you have a history of epilepsy?
☐ Yes | ☐ No Do you have an active carcinoma area /Tumor?
☐ Yes | ☐ No Do you have Blood Clots?
☐ Yes | ☐ No Do you take nitrates such as nitroglycerin?
☐ Yes | ☐ No Have you had a recent Cortisone Injection within the past 72 hours?
☐ Yes | ☐ No Do you have any areas of Active bleeding?
☐ Yes | ☐ No Do you have Migraines stimulated by Light?
☐ Yes | ☐ No Are you currently pregnant or breastfeeding?

* If you answered yes to any of the above questions, then you are not a candidate for Light Therapy.

☐ Yes | ☐ No Do you have any contagious or infectious conditions?

Privacy Statement: I understand that Mary Wisniewski, PA follows the privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA), respects your privacy and will only release medical information about you as permitted or required by law. Mary Wisniewski, PA is an independent contractor at Grand Rapids Natural Health and will uphold the privacy practices of Grand Rapids Natural Health.
By signing this form, I acknowledge that I have received a copy of the Grand Rapids Natural Health Notice of Privacy Practices. I understand that Mary Wisniewski, PA and Energy & Lights, LLC agrees and upholds Grand Rapids Natural Health's privacy practice as stated in the Grand Rapids Natural Health Notice of Privacy Practices.

Arbitration: Any dispute, controversy or claim arising out of or relating to these services shall be exclusively resolved by binding arbitration upon a party's submission of the dispute to arbitration, with arbitration fees to be shared proportionally between the parties.

Consent: By signing below, I agree that I have read and understand the above information. My questions have been fully answered to my satisfaction, and I have made an informed decision to undergo Low Level Pulsed LED Light Therapy.

Ethics Statement:

I, Mary Wisniewski as a Certified Light Therapist, will do no harm, maintain professional conduct and behavior treating everyone with respect and dignity.

I strive to maintain a current and comprehensive level of training, education and experience. It is my intention to meet or exceed any such requirements because the result of good updated training and education that will benefit my clients through better knowledge.

I will encourage my clients to take an active role and personal responsibility for improving and maintaining their own health.

I will provide every client with a focused approach to delivering the benefits of Low Level Pulsed LED Light Therapy.

I will strive to provide emotional support, education and LED Light Therapy pad application to the client in a professional, clean, safe and supportive environment to aid in my clients' progress towards improving wellness.

Cancellation Fee: Please be aware that late cancellations or no-show appointments will be charged 50% of the appointment fee. It is requested that if you must cancel your appointment, that you provide more than 24 hours' notice. A cancellation is late when the appointment is canceled without a 24-hour notice. A "no-show", is a patient who misses an appointment without canceling it. This includes arriving 15 minutes after your scheduled appointment.
Any occurrence of a late cancellation or a "no-show" within 24 hours will be subject to a fee of 50% of the visit applied to the credit card stored on file 24 hours after the visit booking time. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

I give Grand Rapids Natural Health permission to subscribe me to monthly newsletters and promotional deals.
___ yes ____ no

Client Signature	**Print Name**	**Date**

Consent for Parents/Guardians of Minor Client
I attest that I have full legal authority to make decisions for the minor named below, and that I give my permission for him/her to undergo light therapy.

Parent/Guardian Signature	Print Name	Date

Name of Minor Client	Date of Birth