Healing Horizons

Integrated Health Solutions

Welcome to Healing Horizons Integrated Health Solutions

LIGHT THERAPY CONSENT

Thank you for choosing Healing Horizons. We look forward to providing quality healthcare in order to assist you in achieving your health-related goals. To serve you as efficiently as possible, please answer all of the following questions and read and sign all forms. All information will be held in the strictest of confidence.

Name_____ Age_____ DOB_____ M F Marital Status_____ Phone_____

Address_____City/State_____Zip_____

Cell_____ If we may send you information, please provide your email_____

Occupation_____ Emergency Contact_____ Relation_____ Phone_____

Who referred you to Healing Horizons? _____ May we thank him/her? Y N

*I voluntarily consent to be treated with light therapy by April Zappe (doing business as ILLUMINAWORX), a Certified Light Therapist.

*I understand that April Zappe is not a licensed physician or medical practitioner and is not licensed to diagnose or treat specific diseases. If a medical diagnosis or treatment is required, it must be obtained by a licensed physician. Light Therapy is not a replacement for medical treatment or medicine.

*I understand that Light Therapy (also known as photobiomodulation) is a process whereby the device emits a bandwidth of light to certain parts of the body. Low Level Light Therapy must be absorbed to produce biological responses such as pain reduction and increased circulation. Light Therapy is only being utilized for the purpose of pain reduction, increasing localized circulation, and stimulating cellular repair, as per the FDA guidance. It is not intended to treat or cure any disease and should be used in conjunction with a doctor's recommendation.

*As part of the Light Therapy, results are best obtained when the equipment is applied directly to the skin. This may require the practitioner to come in contact your skin or body to ensure proper placement of the equipment. ***Please initial for consent***_____

*Therapy may involve the application of near infrared, red, blue, and/or green light transcranially (on the head) which has been shown to improve blood flow. ***Please initial for consent***_____

*I understand that the rejuvenation process may awaken nerve sensation and there is a possibility of pain as part of this process as circulation is increased. ***Please initial for consent***_____

*I understand there is a possibility for blue light to activate the pigment cells in the skin and there could be a possibility of aging spots or brown spots to develop, which could be temporary or permanent. ***Please initial for consent***_____

*At times you may wish to contact Healing Horizons via email, or vice versa, for communication which may contain protected health information. ***Please initial for consent***_____

*Is there is someone you would like to be able to have access to your patient information, make appointments for you, or communicate with the practitioner? Name_____ Phone_____

Please initial for consent to share information_____

*I understand that my information will be kept confidential according to HIPAA regulations and will not be disclosed to anyone outside of this office without your written consent, unless required by law. ***Please initial*** _____

*I hereby release and hold harmless ILLUMINAWORX, its practitioners, service location, affiliates, agents, employees, equipment, property owners, and any associated persons or entities from any and all liability, claims, demands, actions, or causes of action, including but not limited to any financial liabilities, arising out of or related to any services provided. ***Please initial*** _____

I understand payment is due at the time of service and I agree to address any financial concerns with Healing Horizons prior to treatment. Healing Horizons gladly accepts cancellations up to24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment. Please initial_____

I have carefully read and I understand all of the above information. I am fully aware of what I am signing.

_____

Signature (Patient/Parent/Guardian) Date Rev 9/4//2025

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