CONSENT FORM FOR LOW-LEVEL LIGHT THERAPY (LLLT) TREATMENT

Patient Name: ___________________________________ Date of Birth: _________________

I, ___________________, understand and consent to undergo Low-Level Light Therapy (LLLT) treatment as recommended by the healthcare professional(s) at Nova Vision Center.

1. Nature of Treatment: Low-Level Light Therapy (LLLT) involves the application of specific wavelengths of light to the body for therapeutic purposes. It is a non-invasive treatment that aims to promote tissue healing, reduce pain, inflammation, and improve overall well-being.

2. Purpose and Potential Benefits: The purpose of the LLLT treatment is to potentially provide the following benefits:

    1. Accelerate tissue repair and wound healing
    2. Reduce pain and inflammation
    3. Improve blood circulation
    4. Enhance cellular metabolism and energy production
    5. Aid in relaxation and stress reduction
    6. Chalazion
    7. Dry eyes

3. Risks and Side Effects: While Low-Level Light Therapy (LLLT) is generally considered safe, there are some potential risks and side effects that may occur, including:

    1. Mild warmth or tingling sensation during treatment

    2. Temporary increase in pain or discomfort

    3. Redness, swelling, or bruising in the treated area

    4. Skin irritation or sensitivity

    5. Temporary changes in skin pigmentation

It is important to note that serious adverse reactions are rare. However, if you experience any unexpected or severe reactions, you should inform the healthcare professional immediately.

4. Alternative Treatments: There may be alternative treatments available for your condition. It is important to discuss these options with the healthcare professional(s) to make an informed decision about your treatment.

5. Confidentiality and Data Collection: Your personal and medical information obtained during the Low-Level Light Therapy (LLLT) treatment will be handled in accordance with privacy laws and regulations. It may be used for medical records, research, and statistical purposes while ensuring your identity remains confidential.

6. Treatment Plan and Duration: The treatment plan, including the number of sessions, duration of each session, and frequency, will be discussed and agreed upon between you and the healthcare professional(s) providing the treatment. It is important to follow the treatment plan as prescribed to achieve optimal results.

7. Consent: I have been provided with information regarding the nature of Low-

Level Light Therapy (LLLT) treatment, its potential benefits, risks, and side effects. I have had the opportunity to ask questions and clarify any concerns I may have. I understand that the treatment is voluntary, and I have the right to withdraw my consent at any time.

I voluntarily consent to undergo Low-Level Light Therapy (LLLT) treatment and acknowledge that the healthcare professional(s) have not made any guarantees or promises regarding the outcomes of the treatment.

Patient's Signature: ____ Date: _________________

Witness's Signature: ____ Date: _________________