SHEPHERD UNIVERSITY

Wellness Center

Photobiomodulation (PBM) Therapy New Client Information Sheet

www.shepherdwellness.com

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Photobiomodulation Therapy

THERAPY WAIVER AND CONSENT FORMS

Name:_____ **Date:** _____

Home Address:_____**City:**_____**State:**_____**Zip Code:**_____

Cell phone:_____**Business Telephone:**_____

Date of Birth:_____/_____/_____ **Age:**_____ **Gender:**_____**Email Address:**_____

Referral from:_____**Member of Group**:_____

If no referral or group, how did you hear about us:_____

List the medications you are now taking:

_____ _____ _____

_____ _____ _____

List any allergies you have to drugs, food or other items:

_____ _____ _____

_____ _____ _____

Are you currently under medical care for any reasons? If yes, please explain:

_____ _____ _____

Please check if you suffer or are recovering from any of the conditions listed below:

High blood pressure:	_____	**Kidney Disease:**	_____	**Joint or muscle injuries:**	_____
Stroke:	_____	**Migraines:**	_____	**Areas of chronic pain:**	_____
Joint Diseases:	_____	**Tension headaches:**	_____	**Skin Disease:**	_____
Respiratory Diseases:	_____	**Heart Disease:**	_____	**Digestive Disease:**	_____
Areas of numbness:	_____	**Diabetes:**	_____	**Infectious Disease:**	_____
Paralysis:	_____	**COVID-19:**	_____	**Substance abuse:**	_____

Other serious illnesses or medical conditions (Please Explain):

_____

Please indicate your interest in the following benefits of photobiomodulation (1 indicates great interest, 5 little interest): Recovery from Illness (e.g; COVID) 1 2 3 4 5 Recovery from injury, illness or surgery 1 2 3 4 5 Relaxing treatment 1 2 3 4 5

Improvement of athletic performance 1 2 3 4 5 Relief of pain or stiffness 1 2 3 4 5

Photobiomodulation Therapy

Photobiomodulation (PBM) therapy is a form of low-dose light treatment that has been shown to reduce pain or inflammation and promote healing. PBM uses visible and near-infrared light to selectively inhibit pain receptors or promote resolution of inflammation. It is also able to stimulate the inherent tissue healing and regeneration responses in the body. It has been shown to improve muscle performance and joint motion, by reducing inflammation wherever the light is applied. Treatments typically take between 12 to 20 minutes and is repeated up to three times a week either in a light bed (NovoTHOR), canopy (Kerber USA) or hand-held PBM devices.

CONTRAINDICATIONS FOR PHOTOBIOMODULATION

Published research shows that there are no contraindications established currently to receive locally applied PBM treatments, following the manufacturer's User Instructions. Nonetheless, caution must be exercised with the following conditions, and generally the PBM Center will decline to permit use of a bed or canopy for persons in these categories:

PREGNANCY: Whole body PBM therapy should be avoided in pregnant women as the effects on developing fetus remains unknown. However, local PBM treatments may be used with caution on the pregnant woman as an adjunct to the other modalities to manage back pain or other complaints.

CARCINOMA: Direct PBM treatments on tumors are not recommended. However, application of PBM in other areas of pain is known to benefit supportive cancer care. Any PBM treatment must be performed in consultation with the oncologist, care- givers.

PHOTOSENSITIVITY REACTIONS: Some patients are known to be more photosensitive, and some drugs or natural remedies are known to exacerbate these reactions. A detailed history and careful observation after the first PBM session is recommended. In rare instances, even local treatment may be contraindicated.

- **RESTRICTIONS TO CONTINUING TREATMENTS:** Some patients may report a number of sensations, such as localized feelings of warmth, tingling, or an increase or decrease in symptoms, nausea or dizziness within the 24-hour period immediately following PBM treatments. In patients with persistent or severe treatment reactions, immediate physician consultation and discontinuation of further sessions are recommended.

- **INHERENT RISKS IN ANY THERAPEUTIC EXERCISE**
  Any individual person can possibly incur an adverse reaction to any therapeutic activity, even if all instructions are followed carefully, because every human body has unique characteristics. Each client has to make an informed judgment of whether to accept that statistically remote risk.

PRE-SESSION INSTRUCTIONS

- It is very important that you use following recommendations for optimal benefits:
  - Initial consultation with your primary physician or caregiver is recommended.
  - PBM is a self-service. There is no technician. If the client requires help getting in and out of the bed or canopy, they must bring a caretaker to assist.

- All clients need to book a session 24 hours in advance through the member portal, app, or by calling the front desk.
- Lotions, powder, deodorant, antiperspirant, perfume, makeup or anything topical on the body may reduce benefit. It is recommended these items are not used within 1 hour prior to the session.
- Clients should come showered wearing clothes they can remove quickly and easily.
- For the protection of all the PBM bed users, all lesions must be covered with an adhesive bandage.
- All clients should check in at the front desk to get the PBM room key and ThorLabs glasses.
- All clients must clean the bed with the Lucasol cleaning solution and microfiber rag provided in the PBM room prior to use.
- Make sure the door is set to occupied and push the door firmly shut.
- Clients should disrobe to their level of comfort. However, light cannot easily penetrate thick or layers of clothing, so it is optimal for no/minimal clothing to be worn.

SESSION PROCESS

For PBM Bed

- You will lie on the bed face up for the duration of the session. Suggested session will be between 15 and 20 minutes. No prescription glasses or contacts should be worn. PBM recommended goggles should be worn.
- When the session is complete, the unit will turn off automatically. At that time, please exit the bed and get dressed.

For SunPowerLED Canopy

- You will sit comfortably on a chair or lay on a massage table for the duration of the session. Each session will be 15 minutes- 20 minutes. No prescription glasses or contacts should be worn during the session. PBM recommended glasses or goggles should be worn.
- When the session is complete, the unit will turn off automatically. At that time, please exit the canopy and get dressed.

POST SESSION INSTRUCTIONS

- Spray down the bed or canopy with Lucasol solution.
- Set the door to vacant and close the door when exiting.
- Return the room key and the glasses to the front desk.
- Drink 64-80 oz water within 24 hours of PBM Therapy.
- Resume normal activity.

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CONSENT TO PBM THERAPY

The signature made below is an acknowledgment that: 1) I have read and understand the information about Photobiomodulation Therapy and the protocols for the administration of the therapy. I have been given an opportunity to ask the staff questions and I have received all of the information I desire about the therapy and the procedures. I hereby give my authorization and consent for the administration of PBM therapy, as to each Device modality indicated here by my initials:

_____Use of PBM Bed _____ Use of PBM Canopy

_____ Use of Handheld PBM Device

I agree that I will comply with all instructions on the use of the PBM devices.

This CONSENT shall stand as long as I use the Equipment at the location now and in the future. I can revoke this consent verbally or in writing or by simply exiting the facility, but I do understand that during use of the PBM bed or canopy an attendant may not be instantly available for an immediate verbal revocation/ request to cancel the procedure.

I have read the instructions for proper use of the facilities and do so knowingly. I acknowledge that I am making an informed decision to assume risk, known and unknown, as to any damage or harm that I might incur due to use of the facilities. Because Photobiomodulation should be avoided under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

_____ _____

Client Signature Date

CLIENT'S WAIVER AND RELEASE OF LIABILITY AND HOLD HARMLESS AGREEMENT (Release)

I hereby confirm that no warranty or guarantee, or other assurance, has been made to me relating to the results of the Photobiomodulation Therapy and I assume all risk as to whether the Therapy will produce my desired results. I understand that Photobiomodulation therapy is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension, recovery from muscular tension, and recovery from surgery, illness or injury. I agree to use all sessions within the terms of the contract dates and understand that refunds are not given on unused portions of purchased packages.

I further understand that Photobiomodulation should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that Photobiomodulation technicians are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session should be construed as such.

I have been advised of the risks and hazards connected with the use of the Devices and the PBM Therapy, including the risk of a physical injury; in the event of the remote risk of some injury, there is also a risk that some aspect of the injury may be permanent in nature. I assume all risk as to any known or unknown possible adverse effect.

In consideration for using the PBM device(s) and the administration of PBM Therapy to me, I hereby RELEASE, WAIVE, DISCHARGE, and HOLD HARMLESS Shepherd University, its officers, agents, employees and volunteers (hereinafter referred to as RELEASEES) from any and all liability, claims, demands, actions and causes of action whatsoever, known and unknown, arising out of or related to any loss, damage, or injury, that may be sustained by me, while using the devices or due to the use of the devices for PBM therapy.

I acknowledge that this Waiver, Release and Hold Harmless Agreement shall bind the members of my family and spouse (if any), if I am alive, and my heirs, assignees and personal representative, if I am not alive, and shall be deemed as a RELEASE, WAIVER, AND DISCHARGE of the above named RELEASEES. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of WEST VIRGINIA.

In signing this RELEASE, I Acknowledge And Represent that I have read and understand the entire Agreement, and I am at least eighteen (18) years of age and fully competent to manage my affairs. I understand that I am giving up certain possible legal claims and I execute this Release freely, voluntarily, under no duress or threat of duress, and without inducement, promise or guarantee being communicated to me other than the use of the PBM Therapy as stated in this document.

_____	_____	_____
Client's Printed Name	Signature	Date