YuraMed
826 BUSTLETON PIKE, UNIT 101 A
FEASTERVILLE, PA 19053
215-305-8206

Celluma LED Consent Form

I hereby authorize YURAMED, LLC certified personnel to perform the following procedures or treatments: Celluma light therapy LED (Light Emitting Diode)

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:

Please initial if you* DO NOT *have the following Medical Contraindications:
___Epilepsy
___Multiple Sclerosis (MS)
___Open wounds
___Are currently pregnant or trying to become pregnant
___Porphyria
___Lupus Erythematosis
___Photosensitive Eczema
___Hypomelanism (Albinism)
___Skin Cancer
___Retinal Abnormalities

Light Sensitive Contraindications
Please initial if you DO NOT *have the following Light Sensitive Contraindications:*

___**Chlorpromazine** (Anti-psychotic), also known as Thorazine, Chlorpromazine HcL, Sonazine. You can be treated if the medication has **not been taken within the last 8 days.**

___ **Griseofulvin** (Anti-Fungal), also known as Grifulvin V, Fulvicin P/G, Gris-Peg. You can be treated if the medication has **not been taken within the last 5 days**.

___**Isotretinoin** (Anti-Acne), also known as Accutane. You can be treated if the medication has **not been taken within the last 6 months.**

___**Tetracycline's** (Antibiotic) also known as Retin-A, Renova, Atralin, among others. **You can be treated if Tretinoin is used only at night.**

___**Methotrexate** (Anti-Arthritis & Anti-Cancer), also known as Methotrexate Sodium, PF & LPF, Mexate-AQ, Folex, Trexall. You can be treated if the medication has **not been taken within the last 3 days.**

___**Amiodarone** (Anti-Arrythmic), also known as Amiodarone Codarone x, Pacerone. Treatment can be administered only with your physician's written permission.

___Any herbal supplements such as St. John Warts.

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___ 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 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 understand 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 hereby give my consent and voluntary release to YURAMED LLC from any claims, implied or stated that I have or may have in the future with this treatment, regardless of result. I certify that I have read and fully understand the possibility of known and unknown risks, complications and limitations to this procedure. I agree that this constitutes my full disclosure of my medical and health background. I am stating that the treatment and precautions have been explained to me in great detail and that I fully understand. I give permission to YURAMED LLC specialist to perform the LED procedure we have discussed.

Client Signature: _____Date: __