AZUREWAVE MEDICAL SERVICES

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RED LIGHT THERAPY WAIVER FORM FOR NEW CLIENTS

TheraLight 360 i® Full-Body Red and Near-Infrared Light Therapy
with optional Pulsed Electromagnetic Field (PEMF) technology

CLIENT INFORMATION

Client full legal name _____ Date of birth _____

Phone _____ Email _____ Today's date _____

This waiver applies to voluntary red light therapy sessions provided by AzureWave Medical Services LLC. It supplements, and does not replace, the separate informed consent and health screening form.

ACKNOWLEDGMENT OF THE SERVICE AND POSSIBLE RISKS

1. Voluntary wellness service. I understand that photobiomodulation uses red and near-infrared light and that PEMF may be included only when selected and considered appropriate. My participation is voluntary.
2. No guaranteed result. I understand that individual responses vary. No specific benefit, outcome, cure, diagnosis, or result has been promised or guaranteed.
3. Not a substitute for medical care. I understand that this wellness service does not replace evaluation, diagnosis, or treatment by my physician or other qualified healthcare professional.
4. Possible reactions. I understand that temporary warmth, flushing or redness, skin sensitivity, eye discomfort, headache, dizziness, fatigue, or another unexpected reaction may occur. I will immediately report discomfort or unusual symptoms and may stop the session at any time.
5. Mandatory eye protection and closed eyes. I understand that failure to follow eye-safety instructions may result in eye discomfort, injury, or temporary or permanent eye damage. Eye protection specifically designed for use with red light therapy beds and provided or approved by AzureWave must be worn at all times during the entire session while the lights are illuminated. Ordinary sunglasses are not a substitute unless specifically approved by AzureWave. I must keep my eyes closed at all times while inside the therapy bed and must never stare or look directly into the illuminated LED panels.
6. No cellphone or loose electronic device in the bed. I will not bring a cellphone, smartwatch, earbuds, tablet, or other loose electronic device into the TheraLight therapy bed. I will place these items in the location designated by staff before the session begins.
7. Other safety instructions. I agree to follow all staff and equipment instructions, including instructions concerning positioning, hydration, session duration, and when to discontinue a session.
8. Accurate disclosure. I have disclosed all relevant conditions, medications, devices, and recent procedures. I will promptly report any change before a future session.

SAFETY DISCLOSURES

I will notify AzureWave before treatment if I am or may be pregnant; have active cancer; have received an organ transplant or take immunosuppressive medication; have a photosensitivity disorder; take a photosensitizing medication; have a seizure disorder; have open wounds or skin lesions; recently received a steroid injection; or have any condition that may affect my safe participation.

If PEMF may be used: I will notify AzureWave before treatment if I have a pacemaker, implanted defibrillator, neurostimulator, insulin pump, cochlear implant, or any other implanted or wearable electronic medical device. I understand that AzureWave may postpone or decline a session or request medical clearance.

Client initials - Page 1 acknowledgment _____ Staff initials _____

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Client full legal name _____ Date _____

ASSUMPTION OF RISK AND RELEASE

I understand that no wellness activity is completely free of risk. I knowingly and voluntarily accept the risks associated with my participation in red light therapy and, when used, PEMF, including risks that may be unforeseen.

To the fullest extent permitted by Florida law, I agree that AzureWave Medical Services LLC, Cynthia Meier Ham, MD, and their owners, employees, contractors, and agents are not responsible for any eye injury or eye damage, or for any other injury, complication, adverse effect, loss, damage, or issue arising out of or related to my use of the TheraLight 360 i®, including my failure to wear the required RLT-bed eye protection, keep my eyes closed, avoid looking directly at the lights, keep prohibited items out of the bed, disclose relevant health information, or follow instructions. I knowingly assume these risks and release and hold them harmless from claims arising from my voluntary participation and caused by ordinary negligence. This release does not apply to gross negligence, reckless or intentional misconduct, medical malpractice, or any right or claim that cannot legally be waived.

I accept responsibility for following instructions and for providing complete and accurate health information. I understand that withholding relevant information or failing to follow instructions may increase my risk. If I experience concerning symptoms, I understand that the session may be stopped and that I may be advised to seek medical evaluation or emergency care.

I understand that this waiver remains effective for future sessions unless I revoke it in writing. I also understand that I must report changes in my health, medications, pregnancy status, or implanted devices before each session.

CLIENT ACKNOWLEDGMENT

By signing below, I confirm that I have read this entire waiver, understand it, and have had the opportunity to ask questions. I am signing voluntarily and understand that I may decline or stop the service at any time. I certify that I am at least 18 years old or that my parent/legal guardian is signing below.

Client signature _____ Date _____

Printed name _____

FOR A CLIENT UNDER AGE 18

I certify that I am the parent or legal guardian of the client named above, have authority to sign, and agree to the terms of this waiver on the client's behalf.

Parent/legal guardian signature _____ Date _____

Parent/legal guardian printed name _____ Relationship to client _____

OFFICE USE

Staff/witness signature _____ Date _____