Light Therapy Waiver

I understand that the attending demonstrators are not allopathic doctors (MDs) and do not portray themselves to be but are providing Light Therapy and wellness services. Procedures utilized include stress reduction therapy, nutritional stress/wellness consultation and Light Therapy. I fully understand that the attending demonstrators do not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments. In addition, they do no diagnose, treat or otherwise prescribe for my disease, illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited the attending practitioners' services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my own health. I am fully aware and release One Telemed, LLC to do a Light therapy session, wellness consultation and other stress reduction protocols. By signing below, I acknowledge that I have read and understand all parts of this waiver, that I had the opportunity to ask any questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and I am here on this and subsequent visit solely on my own behalf. By signing, I agree to join One Telemed, LLC's mailing list.

For the diagnosis and treatment of any disease, consult a licensed Physician.

Print Name: ____
Profession: ____
Phone: ________________________ Email: ___________________________
Light sensitive? _____________
History of seizures? _____________ Epileptic? ________________
Top Areas of Concern:
1. ____
2. ____
3. ____

Medial conditions received? _______________________________________
My interest in light therapy today is:
Personal Health: ________Business Interest: _________

Signature: _______________________________________ Date: ________________

Office Use Only- Name:
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