BLATMAN
HEALTH AND WELLNESS CENTER

Informed Consent for Firefly Light Therapy

This document confirms that you are voluntarily seeking joint injection treatment at **Blatman Health and Wellness Center** and acknowledges your understanding of the procedure, its purpose, benefits, risks, and important information.

Purpose of Treatment

The purpose of Firefly Light Therapy is to use targeted light energy to stimulate circulation and support tissue repair. It may help reduce pain and symptoms associated with soft tissue injuries such as swelling, irritation, or delayed healing.

Procedure Information

Firefly Light Therapy uses packets of light (photons) delivered to the treatment area through a handheld device. The light energy is designed to increase local blood flow and stimulate cellular activity. Treatment is non-invasive, generally well tolerated, and performed in-office. Protective eyewear provided by BHWC must be worn at all times to prevent eye injury.

Benefits

- Reduced pain and discomfort
- Improved circulation in the treatment area
- Reduced swelling or inflammation
- Support for healing of superficial injuries such as burns, cuts, or contusions

Risks

- Temporary increase in pain during treatment
- Temporary increase in pain later in the day or in the days following treatment
- Mild bruising from blood flow stimulation or device pressure
- Temporary dizziness
- Reactions related to photosensitizing medications.
- Light-based therapies may pose a risk of eye injury without proper protective eyewear.

Important information

- Individuals taking photosensitizing medications may have a higher risk of reactions.
- Underlying medical conditions may influence treatment response.
- Firefly Light Therapy is not a substitute for emergency medical care or other treatment recommended by your provider.
- You may stop treatment at any time and should notify BHWC if discomfort occurs.
- Results vary depending on the condition being treated.

Consent

By signing below, I acknowledge that:

- I have read and understood this consent form.
- My questions have been answered satisfactorily.
- I agree to wear the protective glasses provided to me at all times during treatment
- I accept the risks and complications of the procedure.
- I voluntarily consent to the performance of joint injections.

Patient Name: _____ **Date:** _____

Patient Signature: _____

Witness Name: _____ **Date:** _____