MIDWEST INTEGRATIVE HEALTH LLC

MIH - Celluma Consent Form

Celluma Consent

Celluma LED Light Therapy is a non-invasive, FDA-cleared treatment that uses low-level light energy to improve cellular health. It is commonly used to treat acne, reduce inflammation, promote skin rejuvenation, and relieve pain through red, blue, and near-infrared light wavelengths.

Purpose of Consent

This form is intended to inform you about the Celluma LED Light Therapy procedure, its benefits, risks, and alternatives, and to obtain your voluntary consent for treatment by Jessica Thorman, APRN, FNP-C, at Midwest Integrative Health.

Procedure Details

The device is placed over or near the treatment area for 15–60 minutes.

Multiple sessions may be recommended for optimal results.

You may experience a gentle warming sensation during treatment.

Protective eyewear may be provided depending on the treatment area.

Potential Risks and Side Effects

Celluma LED Light Therapy is generally safe and well tolerated. However, potential risks include:

• Temporary redness or skin sensitivity

• Mild discomfort or warmth

• Rare photosensitivity reactions

• Contraindications for individuals with epilepsy or light-triggered conditions

Alternatives

• Topical treatments

• Oral medications (for acne or inflammation)

• Laser therapy

• No treatment

Important Considerations

I understand that Celluma LED Light Therapy is a wellness and cosmetic treatment and may not be covered by insurance.

I have disclosed all relevant medical history, including photosensitivity, medications, and skin conditions.

I understand that results vary and are not guaranteed.

I am not pregnant or breastfeeding, or I have discussed this with my provider.

I understand that follow-up sessions may be necessary for best results.

Consent Statement

I consent to receive Celluma LED Light Therapy administered by Jessica Thorman, APRN, FNP-C, or by a qualified member of Midwest Integrative Health

I have had the opportunity to ask questions and all have been answered to my satisfaction.

I understand the nature of the procedure, its risks, benefits, and alternatives.

I voluntarily choose to proceed with treatment.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I HAVE READ AND UNDERSTAND THE SKINVIVE CONSENT FOR MIDWEST INTEGRATIVE HEALTH, LLC, AND THAT I AM SIGNING THIS FORM VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE

Date