



LUMINEXA DESIDERIO

CLIENT / PATIENT ONBOARDING, DISCLAIMER AND CONSENT FORM

SECTION A: CLIENT/PATIENT PERSONAL DETAILS

Who completes Section A? All clients/patients

About You	
Full Name (As per ID)	
Identity/Passport Number	
Date of Birth	
Gender	
Height (in cm)	
Contact Number	
Email Address	
In Case of Emergency (next of kin)	
Name	
Relationship	
Contact Number	

Initial: _____

SECTION B: CLIENT/PATIENT GOAL

Who completes Section B? All clients/patients

What main issue or goal brings you to Luminexa@Desiderio today?

☐	Sports Injury Recovery
☐	Chronic Pain Management
☐	Tissue / Wound Healing
☐	Performance & Conditioning Optimization

Other: _____

Initial: _____



SECTION C: CLIENT/PATIENT GENERAL MEDICAL HISTORY

Who completes Section C? All clients/patients

Do you have any of the following conditions or have you been treated for it previously?		Yes	No
1	Heart related disease		
2	Lung related disease		
3	Type 1 or type 2 diabetes		
4	Arthritis		
5	Cancer or related oncological conditions		
6	High or low blood pressure		
7	Dizziness, light-headedness, or fainting with exercise or exertion		
8	Shortness of breath with mild exertion, at rest, or when lying down/going to bed		
9	Ankle swelling, especially at night		
10	A rapid or pronounced heartbeat		
11	A heart murmur (i.e., an unusual swishing or whooshing sound heard between normal heartbeats) that your doctor has previously diagnosed		
12	Leg or lower leg pain when you walk, which goes away with rest		
13	Ever been advised not to train for any medical reason		
14	Do you have any known Bloodwork reports to submit for evaluation (e.g., at Ampath or Lancet)		
15	Pain or discomfort in your chest, neck, jaw or arms at rest or during physical activity		

Initial: _____

SECTION D: MEDICATION & SUBSTANCES

Who completes Section D? All clients/patients

Please list all prescription medications, over-the-counter drugs, vitamins, and/or peptides you are currently taking:

Name of medication	Dosage	Frequency of use	Is it prescribed as chronic medication?	
			Yes	No

Important: If you are using warfarin/bipolar disorder related and/or other neurological management medication, make sure they are listed in Section C above.

Initial: _____



SECTION E: SURGERY & HOSPITALISATION

Who completes Section E? All clients/patients

Please list all known surgical procedures and/or periods of hospitalisation you had in the past and recently:

Type of Surgery/Hospitalisation	Year	Use this space to describe how you feel after the surgery/hospitalisation (i.e. the outcome)

Initial: _____

SECTION F: INJURIES/OTHER LIMITATIONS FOR CONSIDERATION

Who completes Section F? All clients/patients

Do you have any other injuries/limitations?

Yes	No

If yes, please list/describe them

Initial: _____



SECTION G: PHYSICAL REHABILITATION SCREENING

Who completes Section G? Clients/patients doing physical sport rehabilitation

Please answer Yes (Y) or No (N) to the following safety screening & contraindications questions		Yes	No
1	Do you have a cardiac pacemaker, implanted defibrillator, or deep vein thrombosis (DVT)		
2	Have you undergone orthopaedic surgery or suffered an acute fracture within the last 12 weeks		
3	Do you experience unexplained dizziness, fainting, or chest pain during physical exertion		
4	You have been certified and cleared by General Medical Doctor or specialist to partake in weight bearing exercises or training within prescribed guidelines		

Initial: _____

SECTION H: PHOTOBIMODULATION THERAPY

Who completes Section H? Clients/patients who uses PHOTOBIMODULATION recovery

Please answer Yes (Y) or No (N) to the following safety screening & contraindications questions		Yes	No
1	Are you currently pregnant or nursing		
2	Do you have a history of cancer or active malignant tumours		
3	Do you suffer from light-triggered epilepsy or seizures		
4	Are you currently taking medications that increase light sensitivity (e.g., Roaccutane, antibiotics)		
5	Do you have any tattoos, open wounds, or active skin infections in the treatment area		
6	Do you have any surgical implants and/or replacements (e.g., joints, tooth, soft tissue, pacemaker, cochlear devices)		
7	Do you suffer from claustrophobia (fear of being in small, confined, or enclosed spaces)		
8	Do you have a medical condition or any known skin reaction/allergy when exposed to light		

Initial: _____

SECTION I: PEPTIDE THERAPY & MEDICAL SCREENING

Who completes Section I? Clients/patients interested in PEPTIDE FACILITATED Recovery

Please answer Yes (Y) or No (N) to the following safety screening & contraindications questions		Yes	No
1	Do you have a valid medical prescription from a registered South African medical doctor for the peptides you wish to utilize		
2	Have you been diagnosed with any kidney, liver, or cardiovascular disease		
3	Do you have a history of abnormal tissue growths, cysts, or benign tumours		
4	Do you have a known allergy or hypersensitivity to any peptide compounds		

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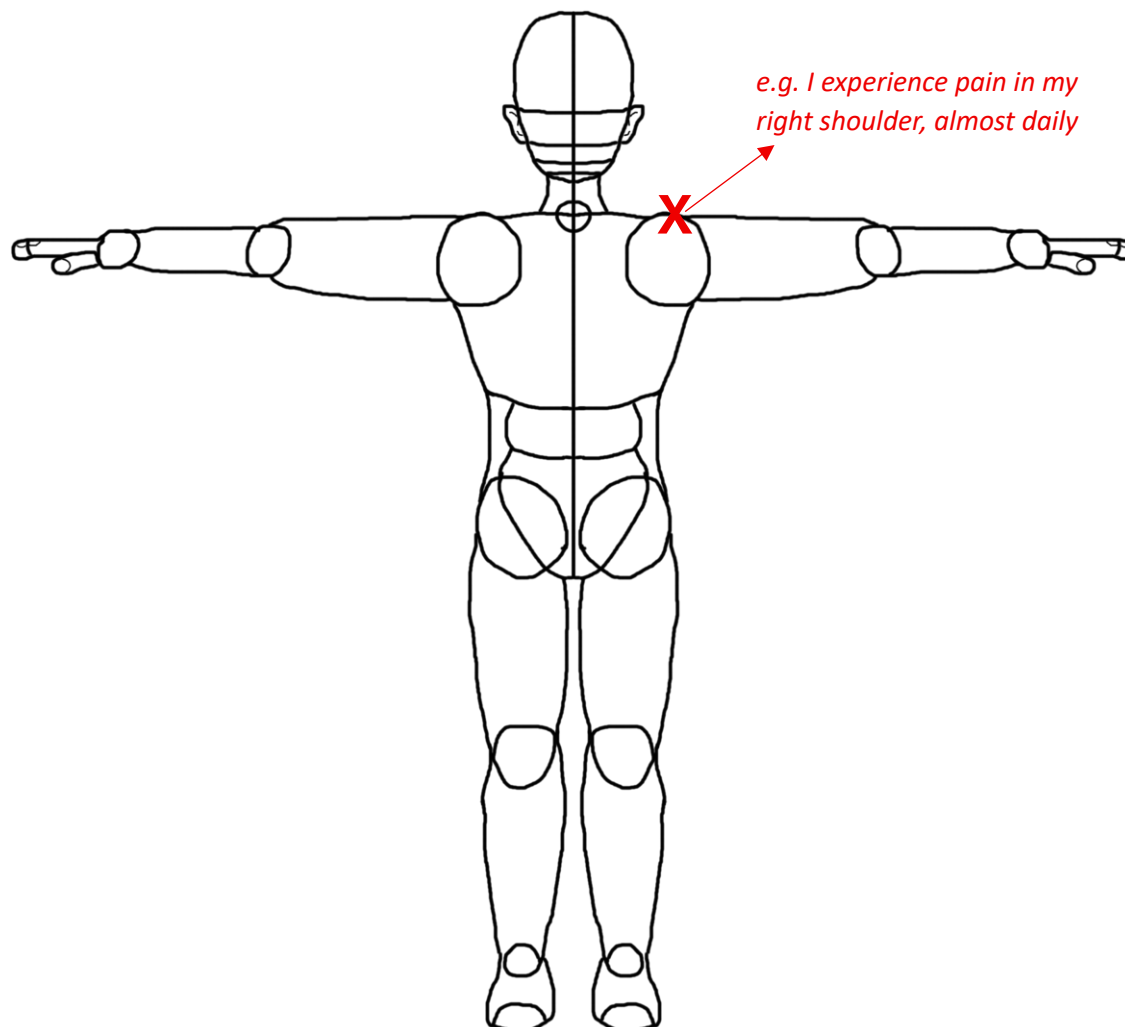


SECTION J: PAIN AND/OR DISCOMFORT CHART

Who completes Section J? All clients/patients

Please clearly circle the areas you are experiencing any discomfort or form of pain (regardless the severity).

Please feel free to comment next to your circled area/s



Initial: _____



SECTION K: CONSENT & DISCLAIMER

Who completes Section J? All clients/patients

General Information and Scope of Services

- All services, therapies, and rehabilitation protocols delivered by PJ Weir-Smith under the business name Luminexa@Desiderio—whether conducted at Vo2Max Fitness Centre or any other physical or remote location—are intended for physical optimization, sports recovery, pain management, and athletic conditioning support.
- These services do not substitute formal medical diagnosis, localized clinical evaluation, or specialized surgical intervention.

Physical Sport Rehabilitation and Fitness Services

- Physical assessments, manual techniques, and recovery exercises are tailored to individual performance levels. It is the client's responsibility to obtain clearance from a general practitioner or orthopaedic specialist before commencing intensive physical rehabilitation following acute trauma or major surgery.

Photobiomodulation (PBM) / Low-Level Laser Therapy (LLLT)

- Client Acknowledgment: By undergoing PBM/LLLT, the client acknowledges that while the technology is generally safe, individual physiological responses vary. Results are not universally guaranteed.
- Contraindications: The client bears the responsibility to disclose if they are pregnant, possess a hearing device or other medical assisted devices, have active diagnosed malignancies, suffer from light-triggered epilepsy, or taking photosensitizing medications. Protective eyewear must be worn.
- I was advised about the process, steps and safety precautions for the planned photobiomodulation therapy, including avoiding the exposure of certain clothing/textures during a photobiomodulation (near infrared and red light) therapy session/s.
- Nature of Treatment: PBM/LLLT is a non-invasive light therapy utilizing specific red and near-infrared wavelengths to stimulate cellular repair and reduce inflammation.

Peptide Facilitated Therapy & Recovery Protocols

- Administration & Scripts: Any peptide-based optimization program supported or administered via these services must be backed by a valid, patient-specific prescription issued by a registered South African medical practitioner and filled by a licensed compounding pharmacy. The client confirms that any therapeutic substances introduced have been legally sourced under medical supervision.
- Regulatory Compliance: In strict accordance with the South African Health Products Regulatory Authority (SAHPRA) and the Medicines and Related Substances Act 101 of 1965, Luminexa@Desiderio does not diagnose medical conditions, independently prescribe, manufacture, or commercially distribute scheduled peptide substances.

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Limitation of Liability

To the maximum extent permitted under the Consumer Protection Act 68 of 2008, PJ Weir-Smith, Luminexa@Desiderio, and the host facility Vo2Max Fitness Centre (including its directors, staff, and affiliates) shall not be held liable for any direct, indirect, incidental, or consequential injuries, medical complications, or adverse reactions arising from a client's failure to fully disclose pre-existing medical conditions, hidden contraindications, or unprescribed substance use.

Legal Declaration & Acknowledgment

- **3D Body Scanning & Light Therapy Consent:** I consent to participating in Luminexa's body intelligence assessments, including 3D body scanning for posture/composition analysis, and utilizing supportive recovery modalities like Low-Level Light Therapy (LLLT). I acknowledge these technologies are used for physical tracking, tissue recovery, and movement optimization, and do not replace professional medical screening, radiology, or dermatological exams.
- **All/any Payment/s:** By making any payments to Luminexa@Desiderio or to PJ Weir-Smith I agree without any reservations to terms and conditions as stipulated in the quote/account/invoice.
- **Assumption of Risk:** I acknowledge that individual physical responses to PBM/LLLT, physical rehabilitation, and peptide support vary. No guarantees regarding specific therapeutic outcomes have been made to me.
- **Consent through first payment:** I was advised to disclose any/all queries related to the LUMINEXA@DESIDERIO TERMS AND AGREEMENT DOCUMENT. By making my first/any payment to Luminexa@Desiderio now and in future without any record of queries raised for discussion, I hereby agree to all listed Terms and Conditions and information completed in above onboarding consent and disclaimer form.
- **Consent to Treatment:** I voluntarily consent to participate in the assessments, physical modalities, and light therapies administered by PJ Weir-Smith under the business entity Luminexa@Desiderio.
- **Data Sharing with External Practitioners:** To ensure an optimal, multidisciplinary approach to my health and physical recovery, I hereby authorize PJ Weir-Smith and Luminexa to share, discuss, and cross-reference my lab reports, 3D scanning profiles, and training data with my treating General Practitioner (GP), registered dietitians, biokineticists, or other licensed healthcare specialists that I designate. I understand my data will be handled securely.
- **Educational & Training Boundaries:** I understand that any review of my blood laboratory reports, biomarkers, or medical history by PJ Weir-Smith and the Luminexa staff is performed strictly to guide my personalized exercise programming, physical rehabilitation, and recovery coaching. PJ Weir-Smith is a professional international personal trainer and rehabilitation specialist, **not** a registered medical doctor, pathologist, or clinical dietitian. PJ Weir-Smith does not diagnose medical conditions, interpret lab values for diagnostic purposes, or prescribe medical treatments.

Initial: _____



- **Liability Release & Medical Oversight:** I confirm that any lab reports provided have been ordered by or reviewed with a qualified medical practitioner. I accept sole responsibility for seeking formal medical treatment for any abnormal medical markers. I agree that any training, lifestyle adjustments, or recovery protocols undertaken are at my own risk, and I release PJ Weir-Smith, Luminexa, and Desiderio from any liability regarding my medical outcomes.
- **Accuracy of Information:** I certify that the information provided in this form is true, accurate, and complete. I understand that withholding medical information can create significant risks to my health.
- **Prescription Verification:** If utilizing peptide therapy protocols, I confirm that these substances have been prescribed to me individually by a registered medical practitioner and legally dispensed by a registered pharmacy.
- **By signing this document, I agree to all the detailed terms and conditions set out in the document named LUMINEXA@DESIDERIO TERMS AND AGREEMENT DOCUMENT. By signing this document, I agree that I have received a copy of the detailed terms and conditions (via hard and/or electronic copy) as set out in the document named LUMINEXA@DESIDERIO TERMS AND AGREEMENT which I can take home to read and study for future compliance.**

Client/Patient

Full Signature:

Date:

Agreed to by PJ Weir-Smith

Full Signature:

Date:
