

# Revitalight™

## Skincare Technology, Inc. Client Skin Care Treatment Consent Form

1. I understand that I should consult a physician or pharmacist before using Revitalight if I am taking prescription or non-prescription medications, or have a history of skin problems.
2. I understand I should consult a physician before my first treatment if I am not sure about my medical condition, or if I have one of the following conditions: 1) pregnancy, 2) epilepsy, or 3) if I take medicine that would cause a sensitivity to light, such as, but not limited to tetracycline.
3. The complete treatment and safety features have been explained to me, and any questions I have regarding this treatment have been explained to my satisfaction.
4. I understand the intended use of Revitalight Skin Care System and the instructions for the Revitalight treatments. I agree to have the Revitalight treatments administered to me at my own risk and hereby release the owners, operators, distributors, and manufacturers from any liability resulting from my use of the Revitalight Skin Care System.
5. I am over 18 years of age.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_