RevLight Skincare System Treatment Consent

Establishment _____ Esthetician Name _____

Unit Number _____

Client consent to treatment:

1. I understand that I should consult a physician or pharmacist before receiving RevLight Skincare System treatments 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 RevLight Skincare System treatment if I am not sure about my medical condition, or if I have one of the following conditions: 1) pregnancy, 2) epilepsy, or 4) if you take medicine that would cause a sensitivity to light, such as tetracycline or Retin-A.

3. The complete RevLight Skincare System 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 RevLight Skincare System and the instructions for the treatments. I agree to have the RevLight Skincare System treatments administered to me at my own risk and hereby release the owners, operators, distributors, and manufacturers from any liability resulting from the use of the RevLight Skincare System.

5. I am over 18 years of age.

Client Signature: _____ Date: _____

Print Name: _____

Phone Number: _____