Pre-Celluma Consent Form: Please circle any of the following that apply to you.

<table>
<tr>
<th>Complete Restriction
If any of the below apply to you, Celluma cannot be performed or is Restricted from certain areas.</th>
<th>Restricted unless approved by Doctor
If any of the below apply to you, Celluma cannot be performed unless appoved by your Doctor.</th>
<th>Other</th>
</tr>
<tr>
<td>• Epilepsy or Seizure Disorder
• Active Cancer/Cancerous Tumors</td>
<td rowspan="3">• Antibiotics
• Diabetic Drugs
• Anti-inflammatory medications
• Diuretics
• Statins
• Anti-fungal medications
• neuroleptic medication
• Chemotherapy drugs
• Cardiac medications
• Children under 12</td>
<td rowspan="3">• Prescription Retin-A must be stopped 1 week before treatment.
• Over-the-counter Retinols must be stopped 48 hours before treatment.</td>
</tr>
<tr>
<td>Partial Restriction</td>
</tr>
<tr>
<td>• Over the belly of pregnant mothers
• Over the breast area of breast feeding mothers</td>
</tr>
</table>

I, _____ hereby acknowledge that I have read and understand the above statements and circled all that apply to me.

Release of All Claims Form: The undersigned, being of lawful age, does hereby forever release and discharge Mitchell's Salon & Day Spa, Inc., it's employee's and agents, shareholders, successors and assigns for and from any and all liability, claims, demands, damages and causes of action, of any kind, including but not limited to personal injuries, medical expenses, pain and suffering, lost wages and all other damages, whether now known or unknown, resulting from the rendering of service's at Mitchell's Salon & Day Spa Inc.

Client Signature:_____ Date:_____

Esthetician Signature:_____ Date:_____