TANGIBLE
TANNING FITNESS

Cryoskin 3.0

Name: _____ Date: _____

Address: _____

City/State/Zip _____Cell phone: _____

Email Address: _____ ___DOB:_____ Age: _____

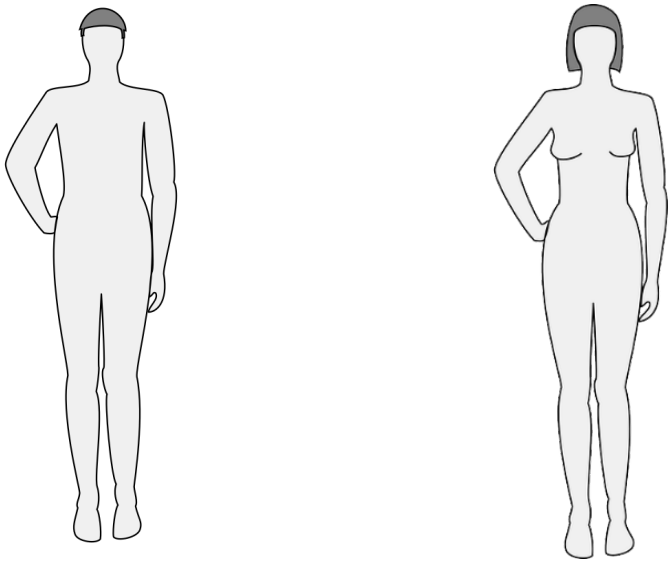
Gender: Male ( ) Female ( ) Height: _____ Weight: _____

Children: Yes ( ) No ( ) Activity Level Low ( ) Moderate ( ) High ( )

Treatment of Interest: Skin Tightening ( ) Cellulite ( ) Slimming ( ) Facial tightening ( )

Brazilian Butt Lift ( ) French Butt (less curvature) ( ) **Referred by: _____**

Please mark all areas of the body you are concerned with:



Background

1. Have you had any other aesthetic procedure (s) before: Yes ( ) No ( )
2. If "yes" what?

_____

TANGIBLE
TANNING FITNESS

_____

_____

3. How did you hear about Cryoskin 3.0? TV ( ) Friend ( ) Internet ( ) Other ( ) _____
4. Do you have any of the following: Please check ALL that apply:

Procedure	Date
○ Botox/Fillers (Last 3 months)	
○ Surgery (last 3 months)	
○ Breast Implants	
○ Pregnant	
○ Breast feeding	
○ Cancer	
○ Cold sensitivity (Reynaud's)	
○ In Vitro Fertilization (IVF)	
○ Open or infected wounds	
○ Scar tissue (in the area to be treated)	
○ Eczema, rashes, or dermatitis	
○ Circulation or heart disorders	
○ Liver or kidney disease	
○ Diabetes (type 1 insulin dependent)	
○ Foreign ointments or lotions on the skin	
○ Tattoo's	
○ Other _____	

Current medications: _____

_____

5. What is your goal with Cryoskin 3.0?

6. Did someone refer you?

TANGIBLE
TANNING FITNESS

Consent, Release and Indemnity Agreement

The Cryoskin safely and effectively uses thermal shock to naturally destroy fat cells without any damage to the skin. The Cryoskin breaks down fat cells, which your body naturally flushes out through the bloodstream and then the lymphatic system in the days to weeks following the session. Cryoskin also helps to reduce the appearance of cellulite, fine lines and wrinkles by stimulating collagen and elastin production while tightening muscles. Cryoskin is also beneficial for facial toning and lifting. Protocols will be discussed and or adjusted during consultation based on recommendations and guest needs. _____Initial

I understand that results may vary depending on individual factors including but not limited to medical history, prior treatments of area being treated, skin type, medication, hormones, patient compliance with pre/post session instructions and individual response to treatment. I understand that I must maintain good dietary habits, have sufficient water intake and participate in light physical activity as well as comply with other items outlined during consultation. _____Initial

Photos will be obtained for records. If pictures are used for education and marketing purposes,, all identifying marks will be cropped or removed, unless the Cryoskin 3.0 treatment is done on the face. We only use the facial photo with your permission. _____Initial

The completed form is for informational purposes only. The and its staff are not medical professionals, and do not claim to be. We are Cryoskin 3.0 experts and hold the highest standards of safety, customer service and education. The Cryoskin 3.0 products and equipment have not been tested or proved by the FDA or any other government agency for the treatment of any illness or disease. Use at your own risk. _____Initial

Cryoskin should not be used on or applied to clients who have certain medical conditions and/or contraindications as listed below:

Contraindication	**Date**
▪ Cryoskin should not be applied over infected or swollen areas of the skin	
▪ Cryoskin should not be applied over or near cancerous areas	
▪ Do you have cancer or a history of cancer?	YES/NO
▪ Are you undergoing active chemotherapy?	YES/NO
▪ Do you suffer from serious kidney disease?	YES/NO
▪ Are you on dialysis?	YES/NO
▪ Do you have any lymphatic drainage disorders?	YES/NO
▪ Have you had Botox or filler within 45 days?	YES/NO
▪ Do you suffer from Type 1 Diabetes?	YES/NO
▪ Do you have loss of sensation in your extremities?	YES/NO

TANGIBLE
TANNING FITNESS

- Are you pregnant, lactating or undergoing IVF? YES/NO
- Do you suffer from Cold sensitivity or Reynauds? YES/NO
- Recent surgery? (last 3 months) YES/NO
- Do you have Eczema, Rashes, or dermatitis? YES/NO
- Have you had breast augmentation or any other elective surgery? YES/NO
- Do you currently have any open or infected wounds? YES/NO
- Do you have any mesh inserts? YES/NO
- Are you currently taking hormone therapy of any kind? YES/NO

The statements above are factual to my knowledge. I understand that any procedure involves risk. Risks may include redness, swelling, irritation, skin reaction, or increased heart rate. Some may experience delays onset muscle soreness from treatments on the stomach due to unintentionally engaging the abdominals, which disappear later the same day. I understand that each person has a different reaction to Cryoskin. The risks, benefits, and possible results have been explained to me. I have been provided the opportunity to ask questions and receive satisfactory responses. _____Initial

I agree to have my photograph taken to document my results. I give permission for any photographs and other audio-visual and/or graphic materials to be used for marketing, education, and/or promotional purposes without any payment to me. I understand that although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I might be identified by the photos. _____Initial

By signing below, I _____, acknowledge and certify that I have read and understand the "Consent, Release and Indemnity" agreement for this treatment, and that I am signing it voluntarily. Should any pain or discomfort occur, I will immediately notify the technician. I understand that I must be at least 18 years old to participate in this treatment. I understand that all sales are final and refunds are not permitted.

Printed Name: _____

Signature: _____

Date: _____

Technician: _____