

Clinical Photo Purchase Guidelines

Sciton encourages all customers to submit clinical (before & after) photos of patients who benefited from treatment with a Sciton product. If a review of the photos determines that they will be purchased, Sciton will pay \$500 per patient treatment result (at least one set of before & after photos).

The following is intended to provide a summary of the guidelines that Sciton uses when evaluating before and after photos for purchase. Sciton will be more likely to use photos if they display the elements described below.

General Photo Criteria

In addition to showing a noticeable clinical result:

1. Before and after photo should be consistent with each other in all elements that make a good photo:
 - a. Lighting (background and subject)
 - b. Distance of subject from camera
 - c. Focus
 - d. Backdrop
 - e. Body area of subject (e.g., Same area of the face should show in both photos)
 - f. Positioning (e.g., The subject's head is tilted to bring a facial area into better view, the head should be tilted by the same angle in both photos)
2. Subject appearance in the following respects should be consistent between the before and after photo:
 - a. Jewelry – Jewelry can be distracting, so it is preferred that it is subtle or not worn.
 - b. Hair – For facial treatments, it is preferred to have the hair pulled back.
 - c. Makeup – It is required that no makeup is worn in the before or after photos.
3. Photos should be crisp and in high resolution JPEG or TIFF format. Minimum file size guidelines:

<u>Camera Megapixels</u>	<u>Pixel Dimensions</u>	<u>Raw Size</u>	<u>Print Dimensions (300 dpi)</u>
2.1	1800 x 1200	6.0 MB	6" x 4"

Required Photo Release Form and Procedure Information

In addition to sufficient photo quality as described above, the following must be provided before the photos can be purchased:

1. Signed "Patient Release Form" from the subject (see below)
2. Sufficient description of treatment (# of treatments at the stage of the photo, product used (e.g., ProFractional-XC), applicable parameters/settings used at each treatment (e.g., depth of ablation % coverage)

Patient Release Form

A. I understand the photograph(s) or video or audio recording(s) taken of me by my physician, his/her staff, or representatives of Sciton, Inc., shall be used in connection with Sciton, Inc.'s dissemination of product information for education and commercial purposes, including without limitation, promotion and advertising, evaluation of medical procedures and sharing of that information with primarily, but not limited to, physicians, surgeons, and others associated with the aesthetic medical industry.

I hereby irrevocably authorize Sciton, Inc. to copy, exhibit, publish or distribute any and all such images and audio of me or wherein I appear, including composite or artistic forms and media, for purposes of publicizing Sciton, Inc.'s products or for any other lawful purpose. In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my likeness appears.

I hereby hold harmless and release and forever discharge Sciton, Inc. from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Street Address: _____

City, State, Zip Code: _____ Telephone: _____

Procedure Information									
Type of Sciton Procedure :									
Treatment Parameters									
	<i>Fluence J/cm²</i>	<i>Pulse Width ms</i>	<i>Rep Rate Hz</i>	<i>Cooling Temp °C</i>	<i>Ablation Depth μm</i>	<i>Overlap %</i>	<i>Density %</i>	<i>Other</i>	<i>Other</i>
<i>Treatment 1</i>									
<i>Treatment 2</i>									
<i>Treatment 3</i>									
How long after treatment is "After" photo? (days, weeks, months):									
Other procedures used:									

Physician Information

B. As physician to the patient noted above, I have a release signed by this patient permitting me unrestricted use of the photos or recordings taken by me or my staff. I hereby assign to Sciton, Inc. the rights to use these media as outlined above.

Physician Signature: _____ Date: _____

Physician Printed Name: _____ Facility Name: _____

Street Address: _____

City, State, Zip Code: _____ Telephone: _____