



CONFIDENTIAL

CRYOTHERAPY CONSENT FORM

*Name _____ DOB _____ Date _____

Address _____

*Phone _____ *E-Mail _____

How did you hear about us? _____

List the medications you are now taking and the respective doses:

List any allergies you have to drugs, food or other items:

Are you currently under medical care for any reasons? If yes, please explain:

DO NOT USE IF YOU HAVE ONE OF THE FOLLOWING:

- PREGNANCY RAYNAUD’S DISEASE COLD ACTIVATED ASTHMA PACEMAKER
- UNCONTROLLED HIGH BLOOD PRESSURE OTHER HEART CONDITIONS
- COLD ALLERGIES UNFIT FOR EXERCISE PERIPHERAL VASCULAR DISEASE (PVD)
- CANCER (UNDERGOING CHEMOTHERAPY) HYPOTENSION HYPOTHYROIDISM

WOMEN ONLY

Are your periods regular? _____

Are you breastfeeding currently? _____

Are you planning to become pregnant soon? _____

PLEASE ALERT STAFF OF CRYOTHERAPY ASSOCIATES LLC IF THERE ARE ANY CHANGES TO YOUR MEDICAL CONDITION AND/OR TREATMENT IN SUBSEQUENT VISITS.

Safety Instructions for Whole Body Cryotherapy:

1. You **MUST** wear cotton or wool socks (and underwear in men) to avoid chilblain, as well as earmuffs and facemask (chamber)
2. Treatments are limited to 3 minutes per session. Overexposure to the cold temperatures may cause chilblain
3. You may end the procedure at any time if you experience any problems or anxiety
4. Abnormal skin sensitivity to cold may be caused by certain foods, cosmetics, or medication, including but not limited to the following: Tranquilizers, High blood pressure medication;
5. A person who is less than (18) years of age may not use whole body cryotherapy without parental consent.

Contraindications to using Cryotherapy:

Pregnancy, severe Hypertension (BP> 180/100), acute or recent myocardial infarction, unstable angina pectoris, arrhythmia, symptomatic cardiovascular disease, cardiac pacemaker, peripheral arterial occlusive disease, cold-activated asthma, venous thrombosis, acute or recent cerebrovascular accident, uncontrolled seizures, Raynaud's Syndrome, fever, Cryoglobulinemia, Cryofibrinogenemia, Agammaglobulinemia, Active Cancer, DVT, Acute infections, Certain medications (antipsychotic, alcohol), Cold intolerance/allergy to cold, Damaged skin, Claustrophobia, Hypothyroidism, symptomatic lung disorders, bleeding disorders, severe anemia, infection, claustrophobia, cold allergy, age less than 18 years (parental consent to treatment needed), acute kidney and urinary tract diseases.

Precautions

Heart valve malfunction, Arrhythmia, Angina, A history of vein thrombosis and clotting, Excessive sweating

Risks of whole body cryotherapy:

Fluctuations in blood pressure (whole body cryotherapy only, due to peripheral vasoconstriction, blood pressure may briefly increase by up to 10 points systolically during treatment), allergic reaction to extreme cold (rare), anxiety, temporary redness of the skin, chill blain/skin burns/scarring (very rare).

Waiver of Liability and hold Harmless Agreement. Please Read:

1. In consideration for undergoing/using the cryotherapy treatments/machines (Equipment), I hereby release, waive, discharge, and hold harmless Cryotherapy Associates LLC, its officers, servants, agents, liquid nitrogen suppliers, employees, heirs, assigns, agents, representatives and volunteers (hereinafter referred to as releasees) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, that may be sustained by any person, while using the equipment or due to the use of the equipment.
2. In consideration for undergoing/using the cryotherapy treatments/machines (Equipment), I release from liability and waive my right to sue Cryotherapy Associates LLC, its officers, servants, agents, liquid nitrogen suppliers, employees, heirs, assigns, representatives, agents and volunteers from all claims, including claims of Cryotherapy Associates LLC's negligence, resulting in any physical injury, illness (including death) or economic loss I may suffer or which may result from my participation in cryotherapy treatments or use of the cryotherapy machines or any injury which may occur on its premises.
3. I hereby confirm that no warranty or guarantee, or other assurance, has been made to me covering the results of the cryotherapy treatments, and I hereby relieve them and hold them harmless from all liabilities for injury or damage that may occur to me. I fully understand the administration of the process, including possible adverse reactions, side effects, or other possible complications. It is understood that this consent is being given in advance of any administration of the process, and is being given by me voluntarily to use the Equipment.

4. I am fully aware of the risks and hazards connected with the use of the Equipment and the receipt of treatments, including the risk of physical injury or disability as the result of such injury, and I am voluntarily participating in said Equipment usage/receipt of treatment, and entering the above named premises to engage in such usage. I voluntarily assume full responsibility for any risks of loss, property damage or personal injury that may be sustained, or any loss or damage to property as a result of being engaged in such an activity. I further hereby agree to indemnify and hold harmless the releasees from any loss, liability, damage or costs that may incur due to the use of Equipment/receipt of treatment by me.

5. I am voluntarily participating in these treatments. I understand that there are risks associated with my participation in these treatments, such as physical and/or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent disability, death or economic loss. These injuries or outcomes may arise from my own or other's actions, inactions, or negligence, or the condition of the Cryotherapy Associates LLC's location (s) or facility (ies). Nonetheless, I assume all risks of my participation in these treatments, whether known or unknown to me, including any events incidental to these treatments.

6. It is my express intent that this Release and Hold Harmless Agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assignees and personal representative, if I am not alive, and shall be deemed as a release, waiver, and discharge of the above named releasees. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of California.

7. I understand that the releasees will not be responsible for any medical costs associated with any injury.

8. I understand that the Equipment is designed for fitness and appearance enhancing use only by persons in good general health. I have been advised that if I suffer from any medical condition or illness whatsoever, I am not to use the Equipment without my doctor's written permission.

My signature below constitutes my acknowledgment that (1) I have read, understand, and fully agree to the foregoing consent, (2) the proposed cryotherapy process has been satisfactorily explained to me and I have all of the information I desire and (3), I hereby give my authorization and consent. This consent shall stand as long as I use the Equipment/treatments at the location now and in the future.

I have read this document, and I am signing it freely. I understand the legal consequences of signing this document, including (a) releasing the District from all liability, (b) waiving my right to sue the District, (c) and assuming all risks of participating in this Activity, including incidents which may occur on Cryotherapy Associates LLC's premises while undergoing cryotherapy.

I have read the instructions for proper use of the facilities and do so at my own risk and hereby release the owners, operators, franchisers, or manufacturers, from any damage or harm that I might incur due to use of the facilities.

In signing this release, I acknowledge and represent that I have read and understand the foregoing Waiver of Liability and Hold Harmless Agreement, I am at least eighteen (18) years of age and fully competent; and I execute this Release for full, adequate, and complete consideration fully intending to be bound by same. Furthermore, I agree that I will comply with all instructions on the use of the cryotherapy devices and that I am using these services at my own risk. I agree to use all sessions within the terms of the contract dates and understand that refunds are not given on unused portions of purchased packages.

Participant's Printed Name

Signature

Date

Participant Parent or Legal Guardian of Participant Name

Signature