CRYO BREEZE
CLIENT INFORMATION & MEDICAL HISTORY

Name _____ Date of Birth _____

Address_____

Phone _____ Email _____

Emergency Contact Name and Phone _____

WHICH BEST DESCRIBES YOUR SKIN?

I. Always burns, never tans
II. Always burns, sometimes tans
III. Sometimes burns, always tans
IV. Rarely burns, always tans
V. Brown, moderately pigmented skin
VI. Black skin

MEDICAL HISTORY:

□ No □Yes Are you currently under the care of a physician? If yes, for what: _____

□No □Yes Are you currently under the care of a dermatologist? If yes, for what: _____

□No □Yes Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation?

Do you have any of the following medical conditions? □ Cancer □ Diabetes □ Hepatitis lesions □ Herpes

□ Arthritis □ High blood pressure □ Skin disease/Skin Lesions □ HIV/AIDS □ Thyroid issues

□ Keloid scarring □ Frequent cold sores □ Seizure disorder □ Hormone imbalance □ Active infection

□ Other? _____

Have you ever had an allergic reaction to □Food □Latex □Medication □Others**:** _____

MEDICATIONS:

What oral medications are you presently taking? □Birth control pills □Hormones □Others:_____

Have you ever used Accutane? □No □Yes, last used it? _____

What topical medications or creams are you currently using? □ Retin-A® □Others:_____

IN THE AREA TO BE TREATED:

Have you used hair removal methods in the past six weeks? □Shaving □Waxing □Electrolysis □Laser removal

□No □Yes Have you had any recent tanning or self-tanning treatments that changed the color of your skin?

□No □Yes Do you form thick or raised scars from cuts or burns?

□No □Yes Do you have Hyperpigmentation or Hypopigmentation If yes, please describe: _____

FOR FEMALE CLIENTS:

Are you pregnant or trying to become pregnant? □Yes □No Are you breastfeeding? □Yes □No

CONSENT, RELEASE AND INDEMNITY AGREEMENT

Cryo treatment should not be performed under the following conditions:

- Applied over areas inflamed, infected, or swollen areas of the skin or varicose veins.
- Applied over/near cancerous areas or on clients with active cancer or undergoing chemotherapy.
- On clients who suffer from kidney disease, undergoing dialysis, or severe diabetes.
- On clients who are pregnant or breastfeeding.
- Applied over areas that have had Botox treatments within 14 days or Filler treatments within 30 days.

I understand that the results of fat and/or cellulite reduction treatment may vary depending on many individual factors, including but not limited to: medical history, skin type, compliance with pre & post-care instructions and individual responses. I understand that for purposes of fat/cellulite reduction and/or skin toning I must maintain good dietary habits, maintain sufficient intake of water and participate in light physical activity as well as comply with all items, instructions and guidelines discussed during consultation prior to session. Protocols will be discussed and or adjusted during consultation based on recommendations and client needs.

I understand that any procedure involves risk. Known risks of Cryo may include, but are not limited to: redness, swelling, irritation, skin reaction, or increased heart rate. Some individuals may experience delayed onset muscle soreness on the stomach due to unintentionally engaging the abdominals. Such muscle soreness ordinarily disappears later the same day. Cryo may also entail risks not presently known or knowable.

COVID-19 Warning. I understand that COVID-19 has been declared a worldwide pandemic by the World Health Organization. The virus that causes COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. I am aware that services may entail proximity to other individuals and human contact and therefore may increase my risk of becoming infected with the Coronavirus.

By signing this agreement: I voluntarily agree to assume all risks of undergoing services, whether included among the known risks listed above, or whether such risks are presently known, unknown or unknowable. I accept sole responsibility for any injury, illness, damage, loss, claim, liability, or expense of any kind that I incur in connection. I agree to unconditionally and forever release, covenant not to sue, discharge, and hold harmless Cryo Breeze employees, successors and assigns from any and all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating to services. I further agree that if any third-party brings legal or equitable claims that in any way relate to or arise from services performed on me against the Company and/or the Company's officers, directors, employees, agents, affiliates, representatives, successors and assigns (the "Indemnified Parties"), I will indemnify the Indemnified Parties for any liability or litigation costs incurred by Indemnified Parties as a result of such claims.

I understand each person has a different response to Cryo. The risks, benefits, and possible results have been explained to me. I have been provided the opportunity to ask questions and received satisfactory responses. I acknowledge and represent that, to the best of my knowledge, I do not have any of the foregoing conditions. 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 staff. I understand that I must be at least 18 yrs old to participate in this treatment.

I understand that all sales are final, and refunds are not permitted. I agree to the 24-hour Cancellation/Reschedule Policy.

I AGREE/ I DO NOT AGREE (Circle) for photos taken during visit to be used for marketing purposes.

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician and to update this history if conditions change.

Client Signature _____ Date _____

Witness Signature _____ Date _____