CryoTherapy Consent

YOUR INFORMATION

Name:

Date of Birth: _____

Gender:

Address: _____

Email:

Phone Number: _____

ASSUMPTION OF RISK, WAIVER, AND RELEASE

By engaging _____ LLC (for the purposes hereof referred to together herein as the "Company") to provide cryotherapy, infrared sauna and related services ("Services") and using the Company's equipment and facilities in relation thereto, I hereby acknowledge on behalf of myself, my heirs, personal representatives and/or assigns, that there are certain inherent risks and dangers associated with receiving Services and my use of the Company's equipment and facilities. At all times, I shall comply with all stated and customary terms, posted safety signs, rules, and verbal instructions given to me by staff. If in the subjective opinion of the Company's staff, I would be at physical risk in receiving Services, I understand and agree that I may be denied access to Services until I furnish the Company with an opinion letter from my medical doctor, at my sole cost and expense, specifically addressing the Company's concerns and stating that the Company's concerns are unfounded.

I hereby (1) agree to assume full responsibility for any and all injuries or damage which are sustained or aggravated by me in relation to my receiving of the Services, (2) release, indemnify, and hold harmless the Company, its direct and indirect parent, subsidiary affiliate entities, and each of their respective officers, directors, members, employees, representatives and agents, and each of their respective successors and assigns and all others, from any and all responsibility, claims, actions, suits, procedures, costs, expenses, damages, and liabilities to the fullest extent allowed by law arising out of or in any way related to the Services, and (3) represent that: (a) I have no medical or physical condition that would prevent me from receiving the Services, (b) I do not have a physical or mental condition that would put me in any physical or medical danger, (c) I have not been instructed by a physician to not receive Services, (d) no warranty or guarantee, or other assurance, has been made to me covering the results of the Services, (e) knowing the risks involved I nevertheless chose to voluntarily request the Services. Notwithstanding the foregoing (and by way of illustration only and not limitation) if any of the following apply to me or if I'm unsure for any reason, I hereby acknowledge the Company's recommendation that I consult a medical physician before receiving Services.

Please initial on the designated lines below:

CryoTheapy Slimming:

- Severe Raynaud's
- Severe Allergy to Cold
- Progressive Diseases (MS, ALS, Parkinson's, Neuropathy)
- Active Cancer

- HIV/AIDS
- Lymphatic Disorders
- Uncontrolled Diabetes or Diabetes-related complications
- Severe Kidney or Liver Disease
- Pregnancy/Breastfeeding
- Bacterial and viral infections of the skin
- Wound healing disorders
- Circulatory disorders
- Surgery in the past 6 months
- Pacemaker/metal implants
- Active/Severe Eczema, rashes, or dermatitis
- Use of topical antibiotics in desired treatment area
- Silicone/other implants in desired treatment area
- Mesh inserts in the desired treatment area
- Irremovable body piercings in the desired treatment area
- Incision scar(s) in the desired treatment area

***I have read and acknowledge the contraindications of Cryo Slimming Treatment. Initial: ____**

CryoTherapy Skin Toning:

- Severe Raynaud's
- Severe Allergy to Cold
- Progressive Diseases (MS, ALS, Parkinson's, Neuropathy)
- Pregnancy/Breastfeeding
- Bacterial and viral infections of the skin
- Wound healing disorders
- Circulatory disorders
- Surgery in the past 6 months
- Pacemaker/metal implants
- Active/Severe Eczema, rashes, or dermatitis
- Silicone/other implants in desired treatment area
- Use of topical antibiotics in desired treatment area
- Mesh inserts in the desired treatment area
- Irremovable body piercings in the desired treatment area

***I have read and acknowledge the contraindications of CryoTherapy Skin Toning Treatment. Initial: ___**

CryoTherapy Facial:

- Severe Raynaud's
- Severe Allergy to Cold
- Progressive Diseases (MS, ALS, Parkinson's, Neuropathy)
- Botox in the past 30 days
- Fillers in the past 90 days
- Bacterial and viral infections of the skin
- Wound healing disorders
- Circulatory disorders

- Metal implants
- Surgery in the past 6 months
- Active/Severe Eczema, rashes, or dermatitis
- Silicone/other implants in desired treatment area
- Use of topical antibiotics in desired treatment area
- Irremovable body piercings in the desired treatment area

***I have read and acknowledge the contraindications of CryoTherapy Facial. Initial: _**

In participating in the Services, you may be photographed, videoed or otherwise recorded by the Company for safety, monitoring and training purposes. You hereby consent to such usage of your imagery for all and any such purpose by the Company and hereby agree that the Company without any payment to you shall in all cases be the sole owner of all intellectual and other proprietary rights therein without any restriction whatsoever.

Your participation in the Services will expose you to extremely cold temperatures. I have read this Assumption of Risk, Waiver, and Release, fully understand its terms, and understand that I am giving up substantial rights including my right to sue the Company under certain circumstances. I acknowledge that I am signing this waiver freely and voluntarily. The term of this waiver is indefinite.
I acknowledge that I have been urged to avoid bringing valuables into and onto the Company's facilities and the Company shall not be liable for the loss of, theft of, or damage to my personal property, including items left in lockers, bathrooms, or anywhere else in the Company's facilities. I acknowledge that no portion of any fees paid by me is in consideration for the safeguarding of valuables.

Photo Consent
Pictures will be obtained for records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed, unless the CryoTherapytreatment is done on the face.
Initial: _____

***Emergency Contact Name:_____*Phone: _____**

Legal Signature:

Date: _____

▢ **By checking this box I agree to have read and agree to the legal agreement above.**