TRIAD OF HEALTH LLC

dba Downtown Gilbert Healthcare

NormaTec® Compression Therapy Liability Waiver

Physical Capability Requirements

Participation in a NormaTec® Compression Therapy session involves exposure to vasopneumatic compression for a short period of time. During the compression therapy session, an Exercise Physiologist will be present during the entire duration of your session. Additionally, you are free to terminate the session at any time.

Contraindications

NormaTec® Compression Therapy is contraindicated for patients with:

- Current or unstable fractures/breaks
- Recent surgery and have sutures/stitches
- Open wounds, contusions, abrasions
- Suspect or known Acute deep vein thrombosis (DVT) (blood clot)
- Severe atherosclerosis (disease of the arteries)/Ischemic vascular disease (IVD)
- Severe congestive cardiac failure (CHF)
- Existing pulmonary edema (having excess fluid in the lungs)
- Existing pulmonary embolism (blood clot in the lungs)
- Extreme deformity of the limbs
- Any local skin conditions such as gangrene, untreated or infected wounds, recent skin graft, or dermatitis
- Known presence of malignancy in the legs or arms
- Limb infections, including cellulitis that have not been treated
- Presence of Lymphangiosarcoma (a rare cancer due to long-standing lymphedema of the upper/lower extremities)

In consideration of being permitted by Triad of Health LLC dba Downtown Gilbert Healthcare to participate in their services for NormaTec® Compression Therapy, I understand it may aggravate a pre-existing medical condition, or could lead to injury. I am voluntarily assuming all risks of accident or injury to me (or my child) arising out of or in any way connected with the use of the services, equipment, or facilities of Triad of Health LLC dba Downtown Gilbert Healthcare.

I hereby release Triad of Health LLC dba Downtown Gilbert Healthcare and its staff members, officers, directors, agents, and assigns from all liability for any damage, injury, or harm, which may be caused by, a result of, or in any way associated with participation in this service of Triad of Health LLC dba Downtown Gilbert Healthcare as a Guest or Member.

I acknowledge that I am at least 18 years of age and otherwise legally competent to sign this release.
Minors require a parent/guardian signature.

Printed Name of Participant _____ **Date of Birth** _____

Signature of Participant _____ **Date** _____

Address_____ **City**_____ **Zip**_____

Phone Number (_____)_____

TO BE READ AND SIGNED BY THE PARENT / GUARDIAN OF MINOR

I hereby state that I am the parent or guardian of the minor whose name and signature appears above. I have carefully read this agreement and fully understand its contents. I acknowledge that this release of liability is a legally binding contract between Triad of Health LLC dba Downtown Gilbert Healthcare and me.

Signature of Parent or Guardian _____ **Date** _____

Printed Name _____