

**WAIVER/RELEASE of LIABILITY**

**Name**: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**:­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Phone**:­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender**:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_\_\_ **Height**: ­­­\_\_\_\_\_\_\_\_\_\_\_\_ **Weight**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently pregnant?** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about Newport Cryotherapy?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you currently feel healthy?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently under medical care for any reason?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History – Do you now or have you had any of the below? (Check all applicable)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| High Blood Pressure |  | Heart Surgery |  | Unstable Angina |  |
| Asthma |  | Shortness of Breath |  | PAO Disease |  |
| Bleeding Tendency |  | Pace Maker |  | Valvular Heart Disease |  |
| Heart Disease |  | Claustrophobia |  | Raynauds Disease |  |
| CHF or CODP |  | Stroke |  | Vasculitis |  |
| Loss of Consciousness |  | Diabetes |  | Kidney or UTI Disease |  |
| Seizures/Epilepsy |  | Severe Anemia |  | DVT |  |
| Any Heart Disorder |  | Heart Attack within 6 months |  | Bacterial/Viral Skin Infection |  |

Any other illnesses or disorders not listed above please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Safety Instructions for Cryotherapy**

1. You must wear the provided gloves and slippers in the chamber to avoid chilblain.
2. Treatments will be limited to 3 minutes to avoid over exposure.
3. During the treatment you must avoid inhaling the nitrogen fumes. Although nontoxic, they are devoid of oxygen and can result in fainting.
4. You may end the procedure at any time if you experience light headedness or anxiety.
5. Abnormal skin sensitivity to cold can be caused by certain foods, medications or cosmetics. (Including but not limited to high blood pressure medication and tranquilizers)
6. Any person under the age of 18 must have parent consent to participate in cryotherapy.

**Waiver of Liability and Hold Harmless Agreement**

1. In consideration for using the cryo device ( Equipment), I hereby RELEASE, WAIVE, DISCHARGE IN ADVANCE, and HOLD HARMLESS CRYO PRO ASSOCIATES, LLC (hereinafter referred to as RELEASEE)along with its DBAS, OFFICERS, OFFICIALS, EMPLOYEES, AGENTS, FRANCHISEES and VOLUNTEERS from any and all liability, claims, demands, actions and causes of actions whatsoever arising out of or related to any damage or injury that may be sustained by me, while using the equipment or due to the use of the equipment.

2. I hereby confirm that no warranty or guarantee, or other assurance has been made to me covering the results of the cryo process. I have been explained and 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.

3. I am fully aware of the risks connected with the use of the Equipment, and I am voluntarily participating in said Equipment usage, and entering the above named premises to engage in such usage. I VOLUNTARILY ASSUME FULL REPSONSIBILITY FOR ANY RISKS that may be in engaged in such activity.

4. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEE from any costs that may incur due to the use of the Equipment by me.

5. It is my expressed intent that this Agreement shall bind the members of my family and shall be deemed as a RELEASE, WAIVER, and DISCHARGE of the above named RELEASEE. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with laws of the State of Rhode Island.

6. I understand that the Equipment is designed for the fitness and appearance enhancing use only by the person 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. If I should faint due to excess nitrogen inhalation, I hold myself responsible for all injuries should I fall, and the cryosauna has the right to assist me.

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

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 (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 cryo device and that I am using these services at my own risk. I agree to use all sessions within terms of the contract dates and understand that refunds are not given on unused portions of purchased packages. By signing below, I affirm that I have read and fully understand the risks as outlined in this waiver. I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL.

­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant Name Printed**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant Signature Date**

**Under 18 Cryotherapy Parent Consent Form**

I, (Printed name: parent or legal Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_acknowledge that I have read and understand the Newport Cryotherapy waiver and acknowledge the risk associated with cryotherapy treatment.

My son/daughter (Print Minor’s Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_has also read and acknowledged the contraindications and waiver of risk. I give consent on behalf of my minor to voluntarily undergo treatment:

**Parent/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minor Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_