sub zero cryotherapy

WAIVER/RELEASE of LIABILITY

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____ Email: _____

Emergency contact Name: _____ Relationship: _____

Emergency Contact Phone: _____ Alternate Phone: _____

Primary Care Physician: _____ Physician Phone: _____

Gender: Male____ Female____ Height: _____Weight:_____

>>>> Are you currently pregnant? _____

How did you hear about Sub Zero? _____
Do you currently feel healthy? _____

Are you currently under medical care for any reason? _____

Medical History: Do you now or have you ever had…? (Please check all applicable):

High blood pressure		Any Heart disorder		Unstable Angina	
Asthma		Shortness of breath		Peripheral artery occlusive disease	
Bleeding tendency		Pacemaker		Valvular heart disease	
Heart disease		Heart Surgery		Raynauds disease	
CHF or COPD		Claustrophobia		Vasculitis	
Loss of consciousness		Diabetes		Kidney or Urinary tract disease	
Seizures/Epilepsy		Stroke		DVT	

Severe Anemia		Heart attack in previous 6 months		Bacterial or viral infections of the skin	

Any other illness or disorder not mentioned above: (Please explain)

What is whole body cryotherapy?

Whole body cryotherapy is the exposure of a person's skin to temperatures of -130 to -170 degrees Celsius (-238 to -274 degrees Fahrenheit) for a period of three minutes or less. When exposed to this temperature, it activates the body's response to extreme cold. The skin responds by increasing collagen production, regaining elasticity, and vasoconstriction to keep the core temperature even. After the procedure, vasodilation occurs resulting in a systemic flush of toxins and stored deposits. This treatment, with regular use, can aid in decreasing inflammation and improving chronic skin conditions.

Safety Instructions for Cryotherapy:

1. You must wear cotton gloves, socks and slippers in the chamber to avoid chilblain.
2. Treatments will be limited to 3 minutes to avoid overexposure.
3. During treatment, you must avoid inhaling the nitrogen fumes. Although non toxic, 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 medications and tranquilizers)
6. Any person under 18 years of age must have parental consent to participate in cryotherapy.

Absolute Contraindications:

- Pregnancy
- Severe Hypertension (BP>180/100)
- Recent Myocardial infarction (<6 months, must be cleared for exercise)
- Uncontrolled seizures
- Symptomatic heart disease
- Recent stroke/CVA
- Fever

- Symptomatic lung disorders
- Bleeding disorders
- Infection
- Intolerance to cold
- Less than 18 years old without consent
- Incontinence

Possible Risks of Cryotherapy:

- Fluctuations of blood pressure (increase 10 points systolic)
- Allergic reaction to cold
- Anxiety
- Activation of latent viral conditions (i.e. cold sores)
- Restlessness at night (due to increased energy levels)

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 Texas.

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's Printed Name Signature
Date

Date: _____

I, (Printed name: parent or legal Guardian) _____acknowledge that I have read and understand the SubZero (Cryo Pro Associates, LLC) 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: _____

Minor Signature: _____