USCryotherapy
FASTER RECOVERY ▪ BETTER HEALTH

CUSTOMER WAIVER

Customer Name: _____ **Birthdate:** _____ **Gender:** _____

Address: _____

Phone: _____ **Cell Phone:** _____

E-mail: _____

EMERGENCY CONTACT

Contact Name: _____ **Relationship:** _____

Contact Phone: _____

Question	YES	NO
Absolute Contraindications		
Have you ever had a heart attack within the previous 6 months?		
Do you have a pacemaker?		
Have you had a heart bypass or valvular disease within the previous 6 months?		
Do you have congestive heart failure?		
Do you have chronic obstructive pulmonary disease (COPD)?		
Do you have an intrathecal pain pump or any electro stimulation implant device? (i.e spinal stimulator implant)		
Do you have any chronic or acute kidney conditions?		
Are you pregnant?		
Relative Contraindications		
Do you have a history of seizure disorders?		
Do you have cold allergies with known skin reactions to cold?		
Do you have any blood disorders (such as hemophilia or blood clots)?		
Do you have any major circulatory dysfunction (such as deep vein thrombosis)?		
Do you have Heart Arrhythmia or Atrial Fibrillation?		
Do you have an Active Cancer diagnosis?		
Other Risk Factors		
Do you have any open wounds, sores, or healing disorders?		
Are you under the influence of drugs or alcohol?		

WAIVER AND RELEASE AGREEMENT

PLEASE READ CAREFULLY BEFORE SIGNING

Physical Capability Requirements

Participation in a Whole Body Cryotherapy (WBC) session involves exposure to extreme cold temperature for a short period of time (not to exceed three and one-half (3:30) minutes per session). During the WBC session, the chamber technician will be present during the entire duration of your session. Additionally, you are free to walk out of the chamber at any time. The cold therapy session is followed by a five (5) to ten (10) minute period of light to moderate exercise.

LIABILITY AND MEDICAL RELEASE AND INDEMNIFICATION AGREEMENT

In consideration of being permitted by US Cryotherapy to participate in their services, I hereby waive any and all claims and damages for personal injury or death which may occur as a result of my participation. I understand and agree that:

1. This release is intended to discharge in advance US Cryotherapy, its officers, officials, employees, agents and volunteers from and against all liability arising out of or connected in any way with my participation in these activities;
2. Participation may involve risk of serious injury, illness, disability or death and may result not only as a result of my actions, negligence or inaction, but also from the action, negligence or inaction of others, including their owners, officers officials employees, or volunteers and may result from the conditions of the facilities, equipment, or areas where such activities are being conducted;
3. Knowing the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate;
4. I will indemnify and hold harmless US Cryotherapy, its owners, officers, officials, employees and volunteers from any loss, liability, damage, cost or expense, including litigation of any form, arising out of or connected in any manner with my participation in such activities;
5. I am in good health and have no physical condition expressed in the 'Contraindications' or otherwise which would preclude me from safely participating in such activities;
6. I understand and agree that this release is intended to be as broad and inclusive as permitted under the law of the State in which it is executed and that if any portion of this Hold Harmless, Release and Indemnification Agreement should be determined to be invalid, it is my intent that the remaining provisions shall continue in full force and effect.

I HAVE CAREFULLY READ THIS RELEASE INDEMNIFICATION AND HOLD HARMLESS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A POTENTIAL CONFLICT BETWEEN MYSELF, AND MY HEIRS AND US CRYOTHERAPY I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL.

____ I understand that it is mandatory to wear a headband, mask, mittens, tube socks, and enclosed footwear during my Whole Body Cryotherapy (WBC) session as a safety precaution. I also understand that I should not remove Personal Protective Equipment (PPE) at anytime during my Whole Body Cryotherapy (WBC) session.

____ I understand that wet or damp clothing cannot be worn at anytime during a Whole Body Cryotherapy (WBC) session. If you need dry clothing, loaner apparel is available upon request at the reception desk for free. Please ask the receptionist for more information.

____ I have completely read this waiver

____ Please *do not* use any photograph taken of me at your facility on your website, in any social media, or any promotional material.

SIGNED BY: _____ **DATE:** _____

If under 18 years of age, parental consent is required. Separate additional consent form available at the front desk. Customers are required to be a minimum of eleven (11) years of age and between the ages of eleven (11) and fourteen (14) must be accompanied by an adult for use of the whole-body cryotherapy chamber

PHYSICIAN'S APPROVAL (IF REQUIRED)

Customer is able to use the Whole Body Cryotherapy (WBC) chamber based on a review of contraindications: **Yes:** _____ **No:** _____

Additional Physician Comments:

Visit www.uscryotherapy.com if you require more information

PHYSICIAN NAME: _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____