

Whole Body Cryotherapy Consent Form

Whole body cryotherapy is the exposure of a person's skin to temperatures of -110° to -200° degrees Fahrenheit for a short time (3 minutes or less). At this extreme temperature, the body activates several mechanisms that are thought to have significant long-term medical and cosmetic benefits to the Skin, Endocrine, Musculoskeletal & Immune Systems.

Safety Instructions for Whole Body Cryotherapy:

1. All parts of body must remain at a distance of comfortable clearance from the active inner rim of the chamber during treatment sessions. **If you cannot maintain this berth, you are not a good candidate for treatment by this device and should not proceed.**
2. You must remove all jewelry and wear cotton or wool socks & gloves (and underwear in men).
3. Treatments are limited to 3 minutes per session.
4. During treatment, your head must remain outside the treatment zone and you must avoid inhaling the nitrogen fumes. While non-toxic, they are devoid of oxygen and may cause fainting.
5. You may end the procedure at any time if you experience any problems or anxiety.
6. Abnormal skin sensitivity to cold may be caused by certain foods, cosmetics, or medication, including but not limited to: tranquilizers & high blood pressure medication.
7. A person who is less than 18 years of age may not use whole body cryotherapy without signed consent of a parent/legal guardian.
8. Do not engage in multiple cryotherapy sessions within less than 48 hours of each other.

Contraindications to using Whole Body Cryotherapy:

- Pregnancy, Severe Hypertension (BP> 180/100), Acute Or Recent Myocardial Infarction, Unstable Angina Pectoris, Peripheral Arterial Occlusive Disease, Venous Thrombosis, Acute Or Recent Cerebrovascular Accident, Arrhythmia, Symptomatic Cardiovascular Disease, Cardiac Pacemaker, Heart Attack, Heart Bypass or Valvular Disease, Congestive Heart Failure, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease (COPD), Spinal Stimulator Implants, Cold Allergies, Major Circulatory Dysfunction, Open Wounds, Sores, or Healing Disorders, Uncontrolled Seizures, Raynaud's Syndrome, Fever, Tumor Disease, Symptomatic Lung Disorders, Blood Disorders, Severe Anemia, Acute Kidney And Urinary Tract Diseases.

Risks of Whole Body Cryotherapy:

Blood pressure may briefly increase by up to 10 points systolically during treatment. This effect should reverse after the end of the procedure, as peripheral circulation returns to normal). Allergic reaction to extreme cold (rare), activation of some viral conditions (cold sores) etc. due to stimulation of the immune system, and/or frostbite are possible. Cryotherapy can also cause claustrophobia, anxiety, lightheadedness/dizziness, numbness, tingling, rashes, redness, and/or irritation of the skin.

1. I understand that Whole Body Cryotherapy is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension and/or recovery from surgery, illness or injury. I further understand that Whole Body Cryotherapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental/physical ailment that I am aware of.
2. I understand that Whole Body Cryotherapy unit operators are not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing said in the course of the session should be construed as such.
3. Because Whole Body Cryotherapy is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the unit operator updated as to any changes in my medical profile and understand that there shall be no liability on the unit operator's part should I forget to do so.

4. I am not under the influence of alcohol and/or narcotics.
5. I hereby confirm that no warranty or guarantee, or other assurance, has been made to me covering the results of the cryo process, and I hereby relieve them and hold them harmless from all liabilities for injury or damage that may occur to me. I fully 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.
6. I am fully aware of the risks and hazards connected with the use of the Equipment, including the risk of physical injury or disability as the result of such injury, and I am voluntarily participating in said Equipment usage, and entering the above-named premises to engage in such usage. I voluntarily assume full responsibility for any risks of loss, property damage or personal injury that may be sustained, or any loss or damage to property as a result of being engaged in such an activity.
7. In consideration for using the cryo device (Equipment), I hereby release, waive, discharge, and hold harmless _____(facility) its officers, servants, agents, employees and volunteers (hereinafter referred to as releasees) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, that may be sustained by any person, while using the equipment or due to the use of the equipment.

My signature below constitutes my acknowledgment 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 I desire; (3) I hereby give my authorization and consent. This CONSENT shall stand as long as I use the Equipment at the facility now and in the future. I have read the instructions for proper use of the facilities & do so at my own risk & hereby release the owners, operators, franchisers, or manufacturers, from any damage or harm that I might incur due to use of the facilities.

Furthermore, I agree that I will comply with all instructions on the use of the cryotherapy device and that I am using these services at my own risk. I agree to use all sessions within the terms of the contract dates and understand that refunds are not given on unused portions of purchased packages.

Client Name (please print): _____ Age: _____

Client Signature: _____ Date: _____

Print Parent or Legal Guardian Name (if client under 18): _____

Parent Signature: _____ Date: _____

Cryotherapy Unit Operator Signature: _____ Date: _____