Compression Therapy Consent and Liability Waiver

Physical Capability Requirements

Participation in a compression therapy session involves exposure to vasopneumatic compression for a short period of time. A licensed medical professional will be available during the entire duration of your compression therapy session. You are free to terminate the session at any time; to do so call for a staff member.

Contraindications

Compression Therapy is contraindicated for patients with:

- Current or unstable fractures/breaks
- Recent surgery and have sutures/stitches to area impacted by compression device
- Open wounds, contusions, abrasions to area impacted by compression device
- Suspect or known Acute deep vein thrombosis (DVT) (blood clot)
- Severe atherosclerosis (disease of the arteries)/Ischemic vascular disease (IVD)
- Severe or uncontrolled congestive cardiac failure (CHF)
- Suspected or known pulmonary edema (having excess fluid in the lungs)
- Suspected or known 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 Our Family Health Center, LLC to participate in their services for 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 Our Family Health Center, LLC. I understand that compression therapy is not an FDA approved treatment for any specific medical condition.

I hereby release Our Family Health Center, LLC 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 Compression Therapy service. I agree that this Compression Therapy Consent and Liability Waiver is in effect for all compression therapy sessions administered by Our Family Health Center, LLC, and will not expire unless specifically requested by either party.

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 Client: ___________________________________

Date of Birth: _______________

Signature of Client: ____

Date: _________________________

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. I have carefully read this Compression Therapy Consent and Liability Waiver and fully understand its contents. I acknowledge that this release of liability is a legally binding contract between Our Family Health Center, LLC, and me.

Signature of Parent or Guardian: ____

Printed Name: ____

Date: _______________________