WHOLE BODY CYROTHERAPY CONSENT WAIVER

Whole body cryotherapy is the exposure of a person's skin to temperatures of -110° to -166° 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 multiple body systems.

Safety Instructions for Whole Body Cryotherapy:

1. All parts of the body must remain at a comfortable clearance from the walls of the cryotherapy machine's chamber during sessions. Do not touch the walls inside of the chamber. If you cannot maintain this berth, you are not a good candidate for cryotherapy and should not proceed.

2. Your skin and hair must be dry before beginning the cryotherapy session.

3. All clothing worn in the chamber must be dry.

4. Dry socks, head and ear covering, mittens, face mask, torso robe and undergarments for women and waist robe and undergarments for men, and provided footwear must be worn during your whole body cryotherapy to ensure a safe experience.

5. All jewelry and clothing containing metal must be removed prior to your whole body cryotherapy session.

6. Sessions are limited to 3 minutes.

7. You may end the session at any time if you experience discomfort of any sort.

8. Abnormal skin sensitivity to cold may be caused by certain foods, cosmetics, or medication, including but not limited to tranquilizers and high blood pressure medication.

9. A person who is less than 18 years of age may not use whole body cryotherapy without signed consent of a parent/legal guardian.

10. Do not engage in multiple cryotherapy sessions within less than four (4) hours of each other.

Direct Contraindications for Whole Body Cryotherapy Use:

Pregnancy, Severe Hypertension (BP> 180/100), Acute Or Recent Myocardial Infarction, Unstable Angina Pectoris (Chest Pain), 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.

If you have any of these conditions, we recommend that you do not use the whole body cryotherapy machine without speaking with your licensed medical provider. I attest that by signing this consent waiver that I have spoken with my licensed medical provider and have been cleared to use the whole body cryotherapy machine.

Risks of Whole Body Cryotherapy:

Blood pressure may briefly increase by up to 10 points systolically during a session. This effect should reverse after the end of the session, 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 musculoskeletal inflammation. 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 licensed medical provider, chiropractor, or other qualified medical specialist for any mental/physical ailment that I am aware of.
2. 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 Our Family Health Center, LLC staff updated as to any changes in my medical profile and understand that there shall be no liability on Our Family Health Center, LLC staff's part should I not do so.
3. I am not under the influence of alcohol and/or narcotics.

Waiver of Liability and Release of Liability

1. In consideration for using the cryotherapy machine (Equipment), I hereby release, waive, discharge, and hold harmless Our Family Health Center, LLC, its officers, servants, agents, employees, heirs, assigns, agents, manufacturers, representatives 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.

2. In consideration for undergoing/using the cryotherapy machine (Equipment), I release from liability and waive my right to sue Our Family Health Center, LLC, its officers, servants, agents, suppliers, employees, heirs, assigns, representatives, agents and volunteers from all claims, including claims of Our Family Health Center LLC's negligence, resulting in any physical injury, illness (including death) or economic loss I may suffer or which may result from my participation in cryotherapy sessions or use of the cryotherapy machines or any injury which may occur on its premises.

3. I hereby confirm that no warranty or guarantee, or other assurance, has been made to me covering the results of the cryotherapy sessions, 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 using the Equipment and is being given by me voluntarily to use the Equipment.

4. 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/receipt of a session, and entering Our Family Health Center, LLC's 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 a cryotherapy session. I further hereby agree to indemnify and hold harmless the releasees from any loss, liability, damage or costs that may incur due to the use of Equipment/receipt of a session by me.

5. I am voluntarily participating in this whole body cryotherapy session. I understand that there are risks associated with my participation in a cryotherapy session, such as physical and/or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent disability, death or economic loss. These injuries or outcomes may arise from my own or other's actions, inactions, or negligence, or the condition of Our Family Health Center, LLC's location (s) or facility (ies). Nonetheless, I assume all risks of my participation in this cryotherapy session, whether known or unknown to me, including any events incidental to these sessions.

6. It is my express intent that this Whole Body Cryotherapy Consent Waiver shall bind the members of my family and partner/spouse, if I am alive, and my heirs, assignees and personal representative, if I am not alive, and shall be deemed as a release, waiver, and discharge of the above named releasees. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of Georgia.

7. I understand that the releasees will not be responsible for any medical costs associated with any injury.

8. I understand that the Equipment is designed for usage only by persons 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.

9. I understand that Cryotherapy sessions are not an FDA approved treatment for any specific medical condition.

My signature below constitutes my acknowledgment that (1) I have read, understand, and fully agree to the foregoing consent, (2) the proposed cryotherapy process has been satisfactorily explained to me and I have all of the information 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 will not expire unless specifically requested by either party.

I have read this document, and I am signing it freely. I understand the legal consequences of signing this document, including (a) releasing the Our Family Health Center, LLC from all liability, (b) waiving my right to sue the Our Family Health Center, LLC, (c) and assuming all risks of participating in a cryotherapy session, including incidents which may occur on Our Family Health LLC's premises while participating in a cryotherapy session.

I have read this Whole Body Cryotherapy Consent Waiver and use the Equipment at my own risk and hereby release the owners, operators, 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 Equipment and that I am using this Equipment at my own risk.

In signing this release, I acknowledge and represent that I have read and understand this Whole Body Cryotherapy Consent Waiver, I am at least eighteen (18) years of age and fully competent; and I execute this waiver for full adequate, and complete consideration fully intending to be bound by same. **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 Whole Body Cryotherapy Consent 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: _____