
## Waiver / Release of Liability

**Name:** _____ **Date:** _____ **Date of Birth:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zipcode:** _____

**Phone:** _____ **Cell Phone:** _____ **E-mail:** _____

**Emergency Contact Name:** _____ **Relationship:** _____ **Emergency Contact Phone:** _____

**Primary Care Physician Name:** _____ **Phone:** _____

**GENDER:** _____**Male** _____ **Female** **HEIGHT:** _____ **WEIGHT:** _____

**How did you hear about Cryo-X?** _____

**ARE YOU TAKING ANY MEDICINES AT THE MOMENT? If yes, please, specify, what and for how long:** _____

**DO YOU FEEL WELL/HEALTHY AT THE MOMENT? (if not, please comment):** _____

**ARE YOU CURRENTLY UNDER MEDICAL CARE FOR ANY REASON? If yes, please explain:**

_____

**If you are female, ARE YOU PREGNANT? (circle one) YES or NO**

**DO YOU HAVE – OR – HAVE YOU EVER HAD…. (Check if answer is yes):**

**High blood pressure:** _____ **Any heart disorders:** _____ **Heart attack in previous 6 months:** _____
**Asthma:** _____ **Shortness of breath:** _____ **Unstable Angina Pectoris:** _____
**Bleeding tendency:** _____ **Epilepsy:** _____ **Peripheral Arterial Occlusive Disease?** _____
**Ischemic Heart Disease:** _____ **Any Heart surgeries:** _____ **Valvular heart disease:** _____
**CHF, COPD, Liver disease:** _____ **Do you have a Pacemaker:** _____ **Any surgeries:** _____
**Sudden loss of consciousness:** _____ **Claustrophobia:** _____ **Raynaud's disease:** _____
**Any serious injury:** _____ **Diabetes:** _____ **Kidney or Urinary Tract disease:** _____
**Seizure Disorder of any kind:** _____ **Stroke:** _____ **Vasculitis:** _____
**Severe Anemia:** _____ **Heavy consumerist diseases (abnormal bleeding):** _____
**Deep Vein Thrombosis (DVT) or a known circulatory dysfunction:** _____
**Decompensating diseases (edema) of the cardiovascular and respiratory system:** _____
**Bacterial or viral infections of the skin, wound healing disorders (open sores or discharging wound/skin conditions):** _____

**Any other illness or disorder: (Please Explain)** _____

_____

## What is Whole Body Cryotherapy?

**Whole body cyotherapy is the exposure of a person's skin to temperatures of -130 to - 170 degrees Celsius (- 238 to – 274 degrees Fahrenheit) for a short time (3 minutes or less). At this temperature, the body activates several mechanisms that have significant long-term medical and cosmetic benefits:**

**The outer skin reacts to the cold by activating an increased production of collagen in deeper layers of the skin (similar to laser treatments of the face, where very high temperatures are used). The skin regains elasticity and becomes smoother and even-toned, significantly improving conditions such as cellulite and skin aging.**
**Skin vessels and capillaries undergo severe vasoconstriction (to keep the core temperature from dropping), followed by vasodilation after the procedure. Toxins and other stored deposits are flushed out of the layers of the skin and blood perfusion is improved after several treatments.**
**The anti-inflammatory properties of cryotherapy are also used to treat chronic skin conditions such as psoriasis and dermatitis.**

## Safety Instructions for Cryotherapy:

1. You must wear cotton socks and gloves to avoid chilblain.
2. Treatments are limited to 3 minutes per session. Overexposure to the cold temperatures may cause chilblain;
3. During treatment, 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 the following: Tranquilizers, High blood pressure medication;
7. A person who is less than (18) years of age may not use whole body cryotherapy without parental consent.

## ABSOLUTE CONTRAINDICATIONS TO USING WHOLE BODY CRYOTHERAPY

Pregnancy, severe Hypertension (BP> 180/100), acute or recent myocardial infarction (heart attack; need to be cleared for exercise), arrhythmia, symptomatic cardiovascular disease, acute or recent cerebrovascular accident (stroke; need to be cleared for exercise), uncontrolled seizures, fever, symptomatic lung disorders, bleeding disorders, infection, claustrophobia, intolerance to cold, age less than 18 years (parental consent to treatment needed), incontinence.

## Possible Risks of Whole Body Cryotherapy:

Fluctuations in blood pressure (due to peripheral vasoconstriction, 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), claustrophobia, anxiety, activation of some viral conditions (cold sores) etc. due to stimulation of the immune system.

## 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 KCAB, LLC (hereinafter referred to as RELEASEE) along with it's DBA's, OFFICERS, OFFICIALS, EMPLOYEES, AGENTS, FRANCHISEE'S and VOLUNTEER'S from any and all liability, claims, demands, actions and causes of action 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 RESPONSIBILITY FOR ANY RISKS that may be engaged in such an activity.
4. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEE from any costs that may incur due to the use of Equipment by me.

5. It is my express intent that this Release and Hold Harmless 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 the laws of the State of Texas.
6. I understand that the Equipment is designed for fitness and appearance enhancing use 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. If I should faint due to excess nitrogen inhalation, I hold myself responsible for all injuries should I fall, and the cryosauna attendant has the right to assist me.
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 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 eighteen (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 the 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 |

**Parental Consent Form for children (under age 18)**

Date: _____

I, (Print name: Parent or Legal Guardian) _____ acknowledge that I have read and understand the Cryo-X (KCAB,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_____