WAIVER OF LIABILITY, MEDICAL RELEASE, CONCENT, AND HISTORY

Name: _____ _____

Address: _____ City: _____

Zip: _____ State: _____

Phone: _____ Email: _____

PLEASE READ BEFORE SIGNING

Participation in a cryotherapy session involves exposure to extreme cold that by nature can be an irritant to certain individuals. At any time you experience pain, discomfort, anxiety, or just want to end session, tell the operator to end session immediately or push the red "end session" button directly in from of you to turn off machine. This is a release of liability and a waiver of certain legal rights.

The following conditions will exclude you from participating in cryotherapy

- Untreated Hypertension
- History of Heart attack, stroke or aneurism
- Cardiovascular or Respiratory Disease; congestive heart failure, COPD, edema.
- Pacemaker or a heart arrhythmia
- Peripheral Arterial Disease
- Deep Vein Thrombosis (DVT)
- The flu or running a high temperature
- Acute kidney and urinary tract diseases
- Severe Anemia
- Cold Allergenic Phenomenon
- Seizure
- Skin lesions, infections or open wounds
- Heart disease or heart surgery
- Raynaud's disease
- Pregnancy
- Vasculitis
- Active Cancer

This list may not be all inclusive, so if you have any particular health problem which you believe would preclude you from participating in exposure to extreme cold, please check with your treating physician before participating.

Clothing

Because of the exposure to extremely cold temperatures, we will provide clothes and garments to wear during session (except undergarments), do not wear your clothes. You need to bring/wear, men (cotton shorts or boxers). Women (cotton swimsuit, shorts, or underwear). Your clothes should contain NO metal (including underwire of bra). All jewelry and piercing(s) must be removed. CryoLife Iowa insists that you wear our dry cotton socks, gloves, and shoes. You must be completely dry and have not metal on your person. You should not exercise one hour prior to treatment. It is recommended that you dry yourself before entering the chamber. Do not apply lotions, oils, or any alcohol based products 12 hours prior to treatment.

Cryotherapy Session

1. Treatments are limited to 3 minutes per session. Overexposure to the cold temperatures may cause chilblain (a form of burn due to cold exposure).
2. During the treatment, you must avoid inhaling the nitrogen fumes. While non-toxic, the fumes are devoid of oxygen and may cause fainting.
3. You may end the procedure at any time. If you experience any problems, you should notify the operator immediately. The TitanCryo sauna has 3 emergency shut offs, one under the monitor for person in sauna.
4. Abnormal skin sensitivity to cold may be caused by many unknown conditions, so let us know if you experience any issues during or post treatment.
5. A person who is less than (18) years of age may not use whole body cryotherapy without parental verbal and written consent as well as their presence during session.
6. YOU MUST FOLLOW ALL SAFETY INSTRUCTIONS OF OPERATOR OF UNIT AT ALL TIMES, DUE TO THE EXTREME COLD NATURE OF CRYOTHERAPY IF YOU HAVE ANY MOISTURE, METAL, OR SYNTHETIC MATERIAL ON YOUR PERSON DURING YOUR SESSION YOU WILL DRASTICALLY INCREASE YOUR CHANCES OF GETTING A COLD BURN AND OR FROST BITE.

Cryotherapy Risks

Fluctuations in blood pressure, adverse reactions to cold, claustrophobia, anxiety and pain.

Zimmerman Chiropractic DBA CryoLife Iowa, 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 clears in advance Zimmerman Chiropractic DBA CryoLife Iowa, its officers, employees from and against any and all liability connected in any way with my visiting Zimmerman Chiropractic and CryoLife Iowa. I have had all questions and concerns answered in full.

2. I hereby confirm that no warranty or guarantee has been made to me as a result of the cryotherapy, and I hereby release, indemnify and hold harmless Zimmerman Chiropractic DBA CryoLife Iowa, its officers, employees, 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 of the processes, and is being given by me voluntarily to participate in a session.

3. 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, employees, nitrogen supply company or other bystanders, may result from the conditions of the facilities or areas where such activities are being conducted.

4. I am fully aware of all of the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate.

5. I will release and hold harmless Zimmerman Chiropractic DBA CryoLife Iowa, its owners, employees 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. I assume full responsibility for any risks of loss, property damage or personal injury that I or my property may sustain.

6. I am in good health and have no physical condition which would preclude me from safely participating in sessions. 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.

7. I understand and agree that this release is intended to be as broad and inclusive as permitted by law. It is my expressed intent that this Release and Hold Harmless Agreement shall bind the members of my family and spouse, my heirs, and personal representatives, shall be deemed as a release, waiver and discharge of all family, friends and business associates. I understand Zimmerman Chiropractic DBA CryoLife Iowa will not be held responsible for any medical, cosmetic or emotional costs associated with any injuries.

8. I understand and agree that cryotherapy is not intended to diagnose or treat any specific disease and that I have had all of my questions fully answered and explained by Dr. Christopher C. Zimmerman D.C., before participating in cryotherapy. I acknowledge I am not to use cryotherapy if I have any health issues without my medical doctor's written permission.

In signing this release, I am agreeing I have read, have had all of my questions answered and understand the process and the proposed cryotherapy process has been satisfactorily explained to me and I have all of the information I desire. I am at least eighteen (18) years of age and fully competent; and I execute this document 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 TitanCryo device and that I am using these services at my own risk.

I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A POTENTIAL CONFLICT BETWEEN MYSELF, AND MY HEIRS AND Zimmerman Chiropractic DBA CryoLife Iowa. I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL.

FAILURE TO CANCEL AN APPOINTMENT 12 HOURS PRIOR TO APPOINTMENT TIME WILL RESULT IN A CHARGE FOR THAT SESSION. ALL SALES AND PURCHASES ARE FINAL AND NON-TRANSFERABLE AND WILL EXPIRE IN 365 DAYS.

Health Information (Please check all that apply)

- Do you have untreated Hypertension? Yes __ No __
- Do you have Peripheral Arterial Disease? Yes __ No __
- Do you have an active Form of Cancer? Yes __ No __
- Do you have any heart disease or have had a heart attack? Yes __ No __
- Have you had heart surgery? Yes __ No __
- Do you have a pacemaker? Yes __ No __
- Do you have diseases of the cardiovascular or respiratory system? Yes__ No__
- congestive heart failure, COPD, or chronic liver disease? Yes __ No __
- Do you have Deep Vein Thrombosis (DVT) or circulatory dysfunction? Yes __ No __
- Do you have Raynaud's disease? Yes __ No __
- Do you have bacterial or viral infections of the skin, wound healing disorders (open sores or discharging wound/skin conditions)? Yes __ No __
- Do you have Vasculitis or any form of edema? Yes __ No __
- Do you have severe anemia? Yes __ No __
- Do you have an untreated thyroid condition? Yes __ No __
- Do you have advanced diabetes? Yes __ No __
- Do you have acute kidney or urinary tract diseases? Yes __ No __
- Do you have any seizure disorders? Yes __ No __
- Do you have Hyperhidrosis - heavy perspiration? Yes __ No __
- Do you have Polyneuropathies? Yes __ No __
- Are you running a fever Yes __ No __
- Are you claustrophobic? Yes __ No __
- Do you have a cold allergy? Yes __ No __
- Are you Pregnant? Yes __ No __
- Have you had any implants or surgical hardware? Yes __ No __
- Are you currently taking any medications, vitamins or supplements? Yes __ No __
  If so, please list:

_____ _____

_____ _____

_____
Printed Name

_____
Signature

_____
Date (mm/dd/yyyy)

_____
Parent or Legal Guardian Signature