Whole Body Cryotherapy User Agreement

PLEASE READ CAREFULLY BEFORE SIGNING

Personal Information:

Date_______________ **User Name**____

Date of Birth_______________________ **Phone/Cell Phone**__________________________

Email____ **Sex:** **M**_____ **F**_____

***FOR MINORS ONLY*: Emergency Contact**____

Contraindications:

Do not use Whole body Cryotherapy if you have any of the following conditions:

- Uncontrolled high blood pressure
- Prior heart attack
- Unstable chest pain
- Disease of blood vessels
- History of blood clots
- Uncontrolled Seizure Disorder
- Cold Allergy
- Open sores
- Nerve pain in feet or legs
- Pregnancy
- Raynnud's Disease
- Conditions or Disease with Increased Sensitivity lo Cold

You may have other conditions that make whole body cryotherapy inappropriate. Consult with your doctor or medical advisor if you have questions as to whether whole body cryotherapy is right for you.

BY SIGNING BELOW YOU CONFIRM TO CRYORECOVERY SAVANNAH, LLC (THE "COMPANY") FOR THE BENEFIT OF THE RELEASED PARTIES (AS LATER DEFINED) THAT YOU HAVE CAREFULLY READ BOTH PAGES OF THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS, VOLUNTARILY AGREE TO EACH OF ITS TERMS AND PROVISIONS, AND SIGN OF YOUR OWN FREE WILL.

User Signature: ____

***FOR MINORS ONLY*: Parent/Legal Guardian Signature:** ______________________________

[Agreement is continued on next page)