



CONSENT FORM – WHOLE BODY CRYOTHERAPY

I have had a consultation either by way of an on-line or in-person presentation, in which I have been advised of the benefits and potential side effects of whole body cryotherapy and I consent to receiving treatment.

I UNDERSTAND THAT IN RELATION TO WHOLE BODY CRYOTHERAPY:

- I must wear dry cotton or wool socks, dry cotton or wool gloves, and dry underwear, to avoid frostbite.
- I must wear protective shoes/clogs.
- Treatments are limited to three (3) minutes per session.
- Overexposure to the cold temperatures may cause frostbite;
- During treatment, I must avoid inhaling the nitrogen fumes; while non-toxic, they are devoid of oxygen and may cause fainting or in certain circumstances even death.
- I must ensure my head is lifted a minimum of 15cm above the edge of the cryosauna so I can breathe the air from the room and not the mixture of gases from the cryosauna.
- I must have dry skin without recent application of lotions and moisturizers.
- I may end the procedure at any time if you experience any problems or anxiety.
- 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.
- A person who is less than eighteen (18) years of age must not use whole body cryotherapy without parental or guardian consent.
- I must not wear any jewelry during your treatment.
- I must be in visual contact with the operating staff during the entire treatment procedure.
- I must follow all instructions on the use of the cryosauna during your treatment.
- I should not use whole body cryotherapy if I have any of the following: pregnancy, hypertension (BP > 180/100), acute or recent myocardial infarction, unstable angina pectoris, arrhythmia, symptomatic cardiovascular disease, cardiac pacemaker, peripheral arterial occlusive disease, asthma, venous thrombosis, acute or recent cerebrovascular accident, uncontrolled seizures, Raynaud's Syndrome, fever, tumor disease, symptomatic lung disorders, bleeding disorders, severe anemia, infection, claustrophobia, cold allergy, acute kidney and urinary tract diseases.
- Fluctuations in blood pressure may occur (due to peripheral vasoconstriction, blood pressure may briefly increase by up to 10 points systolically during treatment). This effect should dissipate upon completion of the procedure, as peripheral circulation returns to normal).
- I may experience an allergic reaction to the extreme cold (rare), claustrophobia, anxiety, temporary redness of the skin, or chilblains (rare).
- Eating healthily is required in the weeks leading up to your treatment, to optimise the results.



Regardless of precautions taken, I acknowledge the possibility of an adverse reaction and accept sole responsibility for any medical care that may become necessary.

If I pre-pay for treatments, I will save an amount according to the pre-payment schedule. I am aware that there is no refund on pre-pays and that they are not transferable to other individuals, treatments or clinics and that pre-pays have a 6-month expiry date (less than 5 treatments) or an 18-month expiry date (5 or more treatments). I am further aware that 72 hours notice is required for any appointment cancellations. If I cancel within 72 hours or do not attend an appointment, a cancellation fee of 50% of the treatment cost will apply. In the case of prepaid treatments, the treatment will be forfeited. I have read all the material provided and have had all my questions satisfactorily answered. No representations have been made in relation to the effectiveness of the treatment. I have obtained or have elected at my own risk not to obtain the advice of an independent medical practitioner in relation to this treatment in respect of any possible adverse health risks. I consent to undergoing the treatment at my own risk.

RELEASE AND INDEMNITY

In consideration of CryoX Enterprise providing me with whole body cryotherapy treatments, and for other good and valuable consideration, the receipt and sufficiency of which is acknowledged, I hereby agree to:

- (a) waive any and all claims that I have or may have in the future against CryoX Enterprise and their owners, therapists, doctors, nurses, volunteers, directors, officers, employees, and independent contractors, (hereinafter referred to as the "Releasees") and to release the Releasees from any and all liability for any loss, damage, expense or injury including death that I may suffer, due to any cause whatsoever, including negligence, breach of contract, or breach of any statutory or other duty of care, on the part of the Releasees, and including the failure on the part of the Releasees to safeguard or protect me from any risks associated with the administration of the treatments;
- (b) hold harmless and indemnify the Releasees from any and all liability for any property damage or personal injury to any third party resulting directly or indirectly from treatments I have received from the CryoX Enterprise; and
- (c) hold harmless and indemnify the Releasees from any and all liability, losses, claims or costs I suffer which are caused or contributed to by, and resulting from, directly or indirectly, any act or omission of the Releasees.

Name:

IC Number:

Date: