



Cryotherapy Waiver & Release Agreement

Please Read Carefully Before Signing

This is a release of liability and a waiver of certain legal rights. A whole body cryotherapy session involves exposure to extreme cold temperature for a short period of time (not to exceed three (3) minutes per session). Below is a list of absolute 'Contraindications' which will preclude you from whole-body cryotherapy. In addition, PLEASE BE AWARE, that if you experience any pain or mental or physical discomfort at any time during the process, you are advised to terminate the session immediately upon your own volition. You will be observed by a technician the entire time while in the chamber, but are free to walk out of the chamber at any time

If you have a health problem which you believe would preclude you from participating in exposure to extreme cold, please check with your primary physician before participating in Cryotherapy.

Liability, Medical Release & Indemnification Agreement

In consideration for being permitted by Cryo Innovations LLC and Wellington Revive to participate in their Whole-Body Cryotherapy, 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. I have no Absolute Contraindications listed above for Whole Body Cryotherapy
2. This release is intended to discharge in advance Cryo Innovations LLC and Wellington Revive, its' officers, officials, employees, agents and volunteers from and against all liability arising out of or connected in any way with my participation in these activities
3. Knowing the risks involved and the contraindications related, I nevertheless voluntarily choose to participate
4. I will indemnify and hold harmless Cryo Innovations LLC and Revive, it's owners, officers, officials, employees and volunteers 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
5. I am in good health and have no physical condition expressed in the 'Absolute Contraindications' or otherwise which would preclude me from safely participating in such activities
6. I understand and agree that this release is intended to be as broad and inclusive as permitted under

Florida law and that if any portion of this Hold Harmless, Release and Indemnification Agreement should be determined to be invalid, it is my intent that the remaining provisions shall continue in full force and effect.

Contraindications:

- Peripheral Arterial Occlusive Disease
- Ischemic Heart Disease
- Decompensating Diseases (edema) of the Cardiovascular System
- Unstable Angina Pectoris
- Untreated Hypertensions
- Heart Attack
- Respiratory System, Congestive Heart Failure, COPD, or Chronic Liver Disease
- A Blood Clot
- Circulatory Dysfunction
- Raynaud's Disease
- Bacterial or Viral Infections of The Skin
- Wound Healing Disorders (open sores or discharging wound/skin conditions)
- Peripheral Arterial Occlusive Disease
- Ischemic Heart Disease
- Decompensating Diseases (edema) of the Cardiovascular System
- Valvular Heart Disease
- Heart Surgery Conditions
- Pacemaker or Defibrillator
- Unstable Angina Pectoris
- Untreated Hypertensions
- Heart Attack
- Pacemaker or Defibrillator
- Respiratory System, Congestive Heart Failure, COPD, or Chronic Liver Disease
- A Blood Clot
- Circulatory Dysfunction

- Raynaud's Disease
- Bacterial or Viral Infections Of The Skin
- Wound Healing Disorders (open sores or discharging wound/skin conditions)
- Wet Skin

I HAVE CAREFULLY READ THIS RELEASE INDEMNIFICATION AND HOLD HARMLESS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A POTENTIAL CONFLICT BETWEEN MYSELF, AND MY HEIRS AND CRYO INNOVATIONS LLC AND REVIVE I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL.

Sign your first and last name below as your representation that you have read and agree to the Liability and Medical Release and Indemnification waiver in its entirety.

Patient Name (print)

Date

Patient Signature