



Recovery and Wellness through Cryotherapy

6001 Egan Drive * Suite 191 * Savage, MN 55378 * 952-220-2997 * cryostrong.com

Physical Readiness Questionnaire

Date: _____ **Customer Name:** _____

Address: _____ **City:** _____

Date of Birth: _____ **Phone/Cell Phone:** _____

Email: _____ **Sex: M** _____ **F** _____

Emergency Contact: _____

Phone: _____ **Contact Relationship:** _____

WAIVER AND RELEASE AGREEMENT

PLEASE READ CAREFULLY BEFORE SIGNING

This is a release of liability and a waiver of certain legal rights.

Participation in a Whole Body Cryotherapy session involved exposure to extreme cold temperature for a short period of time (not to exceed three (3) minutes per session). After the cold therapy session it is recommended that you follow with a five to ten minute period of light exercise. Below is a list of 'absolute contraindications', which will preclude you from participation in WBC. 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 cryotherapy chamber, but are free to walk out of the chamber at any time.

What is Whole Body Cryotherapy?

Whole Body Cryotherapy is the exposure of a person's skin to temperatures of -130 to -170 degrees Celsius (-238 to -274 degrees Fahrenheit) for a period of three minutes or less. When exposed to this temperature, it activates the body's response to extreme cold. The skin responds by increasing collagen production, regaining elasticity, and vasoconstriction to keep the core temperature even. After the procedure, vasodilation occurs resulting in a systemic flush of toxins and stored deposits. This treatment, with regular use, can aid in decreasing inflammation and improving chronic skin conditions.

Safety Instructions for Whole Body Cryotherapy:

1. You must wear DRY cotton or wool socks, DRY cotton or wool gloves, DRY underwear (men), to avoid chilblain; and protective slippers.
2. Treatments are limited to a maximum of 3 minutes per session. Overexposure to the extreme 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. You will be lifted so that your head is a minimum of 15 cm above the edge of the cabin of the cryosauna to allow you to breathe the air from the room and not the mixture of gases from the cabin.
4. You may end the procedure at any time if you experience any problems or anxiety.
5. Abnormal skin sensitivity to cold may be caused by certain foods, cosmetics, or medications, including, but not limited to the following; tranquilizers, high blood pressure medication.
6. A person who is less than (18) years of age may not use whole body cryotherapy without parental consent.
7. You must take off all jewelry to avoid chilblain.
8. You must be in visual contact with the operating staff during the cryotherapy session.
9. You must follow all instructions on the use of the equipment (cryotherapy sauna).

LIABILITY AND INDEMNIFICATION AGREEMENT

In consideration for being permitted by MMRC Group Inc. DBA CryoStrong INC, to participate in a voluntary Cryotherapy activity, 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 is intended to discharge in advance MMRC, Group Inc. DBA CryoStrong, 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.
2. Participation may involve risk of serious injury, illness, disability or death and may 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, officials, employees, or volunteers, and may result from the conditions of the facilities, equipment, or areas where such activities are being conducted.
3. My participation in Whole Body Cryotherapy is VOLUNTARY and DONE AT MY OWN RISK. I hereby confirm that no warranty, guarantee, or other assurance has been made to me by MMRC, Group Inc. DBA CryoStrong or its Agent covering the results of the cryotherapy process, which has been explained to me. I understand the administration of cryotherapy, including possible adverse reactions, side effects, or other possible complications from it. I understand, consent, and agree to assume those risks in advance of any Whole Body Cryotherapy, from the use of the Equipment or use of the Equipment on me or from entering the CryoStrong premises to engage in such usage.
4. I will indemnify and hold harmless MMRC, Group Inc. DBA CryoStrong, its' 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 'Contraindications' or otherwise which would preclude me from safely participating in such activities.
6. I understand that MMRC, Group Inc. DBA CryoStrong will not be responsible for any medical costs associated with any injury.
7. Because Cryotherapy is contraindicated under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the operating staff updated as to any changes in my medical profile and understand that there should be no liability on the operating staff's part should I forget to do so.
8. I understand and agree that this release is intended to be as broad and inclusive as permitted under 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 a in full force and effect.
9. My signature below constitutes my acknowledgement that (1) I have carefully read this entire Agreement and fully understand and agree to be bound by its contents, (2) the proposed indoor Cryotherapy 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 Agreement shall stand as long as I use the Equipment at the location now and in the future. I have read the instructions for proper use of the facilities and do so at my own risk and hereby release MMRC, Group Inc. DBA CryoStrong, owners, operators, franchisers, or manufacturers, from any damage or harm that I might incur due to use of the facilities.

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 MMRC GROUP, INC DBA CRYOSTRONG, I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL.

We acknowledge that we are not medical professionals and that we can only share with you what positive results we have seen historically with clients. We are only offering access to the therapy with no promises of any results. Every client is different and responds differently to the therapy.

I have completely read this waiver.

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

Signed by: _____ Date: _____

Contraindications acknowledgement:

Severe Cardiovascular Conditions:

Do you have Untreated Hypertension?	Yes_____	No_____
Do you have Peripheral Arterial Occlusive Disease?	Yes_____	No_____
Have you had a heart Attack within the previous 6 months?	Yes_____	No_____
Do you have Valvular Heart Disease?	Yes_____	No_____
Do you have Unstable Angina Pectoris?	Yes_____	No_____
Do you have Ischemic Heart Disease?	Yes_____	No_____
Do you have any heart surgery conditions?	Yes_____	No_____
Do you have a Pacemaker?	Yes_____	No_____
Do you have Decompensating diseases (edema) of the Cardiovascular and Respiratory System, Congestive Heart Failure, COPD, or Chronic Liver Disease?	Yes_____	No_____

Circulatory/Skin Conditions:

Do you have Deep Vein Thrombosis (DVT) or a known 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 wounds)?	Yes_____	No_____
Do you have Vasculitis?	Yes_____	No_____

Blood Disorders:

Do you have Severe Anemia?	Yes_____	No_____
Do you have Heavy Consumerist Disease (abnormal bleeding)?	Yes_____	No_____

Conditions of the Nervous System/Kidney & Liver Function:

Do you have Diabetes?	Yes_____	No_____
Do you have Acute Kidney or Urinary Tract Disease?	Yes_____	No_____
Do you have any Seizure Disorders?	Yes_____	No_____
Do you have Hyperhidrosis (heavy perspiration)?	Yes_____	No_____
Do you have Polyneuropathies?	Yes_____	No_____

Other General Health Conditions:

Do you have Acute Febrile Respiratory Conditions?	Yes_____	No_____
Are you Claustrophobic?	Yes_____	No_____
Do you have Cold Allergenic Phenomenon? (known allergy to cold contact)	Yes_____	No_____
Are you Pregnant?	Yes_____	No_____

Risks of Whole Body Cryotherapy:

Fluctuations in blood pressure (due to peripheral vasoconstriction, systolic blood pressure may briefly increase by up to 10 points 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, temporary redness of the skin, chilblain (rare).

Signed By: _____

Date: _____

Parental Consent Form for Minors under the age of 18

Date: _____

I, (Print Name: Parent or Legal Guardian) _____,
acknowledge that I have read and understand the MMRC, Group Inc. DBA
CryoStrong INC waiver and acknowledgement of risk regarding 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 _____

- I give consent on behalf of my minor to voluntarily undergo **future** treatments.

Parent/Guardian Signature _____

Minor Signature _____