FROSTFIT CRYO
Body Contouring Consent Form

Client Information & Consent Acknowledgement

Name:_____
Date:_____
Phone:_____
DOB:_____

Treatment Overview

You are scheduled for a series of non-invasive treatments using an Electromagentic Stimulation device. This treatment is indicated for:

- Non-invasive lipolysis (fat breakdown) and reduction in abdominal circumference
- Improvement of abdominal tone and muscle strengthening
- Firming and toning of the abdomen, buttocks, thighs, calves, and arms

Each session typically lasts 20–30 minutes. To achieve optimal results, completion of a full treatment series is recommended. Additional sessions may be required depending on your goals.

Preparation Guidelines:

- No special preparation is needed, though hydration is encouraged
- Wear comfortable clothing for proper positioning
- Remove all metallic items and electronic devices

During Treatment you will experience strong muscle contractions and a warming sensation in the treated area. No anesthesia or recovery time is required; daily activities may be resumed immediately after.

Health Questionnaire (Please check YES or NO for each condition)
Treatment Considerations

- I understand that smoking, excessive alcohol, eating disorders, or medications may reduce treatment effectiveness. A healthy lifestyle is encouraged.
  Initials: _____
- I will NOT wear metallic items during the session and confirm I have no metallic/electronic implants.
  Initials: _____
- I acknowledge the treatment is not applied over the head, heart, or neck.
  Initials: _____
- I understand pregnant women cannot undergo treatment and acknowledge that I am not pregnant.
  Initials: _____
- I acknowledge there may be rare instances of localized overheating.
  Initials: _____
- I understand possible side effects include muscle pain, temporary spasms, joint pain, and redness.
  Initials: _____

- I acknowledge treatment is not suitable for injured or impaired muscles.
  Initials: _____
- All known risks associated with this procedure have been explained to me and I expressly accept those risks, along with any unknown risks associated with this procedure.
  Initials: _____
- I understand results vary individually and may not meet my personal expectations despite full treatment. I acknowledge further that no warranty or promises of any specific results have been made to me prior to obtaining treatment, and that I am undertaking treatment on my own accord, without any expectation of a specific result.
  Initials: _____
- I confirm I have read and understood this document and had all questions answered to my satisfaction.
  Initials: _____

Client Agreement

My signature below confirms the accuracy of the information provided and my understanding of the Electromagnetic Stimulation procedure and associated risks.

Based on the above, YOU VOLUNTARILY ASSUME FULL RESPONSIBILITY for engaging in the said services and AGREE TO INDEMNIFY AND HOLD ARCTIC ESSENCE, LLC d/b/a FROSTFIT CRYO HARMLESS ("FrostFit Cryo") from any consequences and related costs that may incur due to your use of any of the treatments.

You also acknowledge that you have been given no warranty or guarantee of any particular results. You understand that the outcome depends not only on the treatments, but also on diet, lifestyle choices, and numerous other factors outside of FROSTFIT CRYO's control.

Client Name: _____
Client Signature: _____
Date: _____

Photography Consent

As part of your treatment, clinical photographs/videos may be taken before, during, and after your sessions. These photographs/videos are used to document progress and results. Please indicate your preference regarding the use of these images:

_____ CONSENT TO OPEN PUBLICATION. I give my consent to **anonymous** publication of my progress images/videos in a journal, textbook, marketing materials or open access websites which may be seen by wellness professionals outside **FrostFit Cryo**, as well as members of general public. Anonymity means focus only on the treated body part and not showing my full face or disclosing my name.

_____ CONSENT TO RESTRICTED EDUCATIONAL USE. I agree with **anonymous** use of my progress images/videos only by professionals for the purposes of cryotherapy research and education of people seeking to become professionals. Anonymity means focus only on the treated body part and not showing my full face or disclosing my name.

_____ CONSENT TO CASE NOTES ONLY. I understand that the illustrations requested here, to which I have agreed, will only form part of my confidential treatment records and will be used by nobody but the **FrostFit Cryo** staff directly involved in providing the services of my choice.

Client Name: _____
Client Signature: _____
Date: _____