FROSTFIT CRYO
NEW CLIENT INTAKE FORM & CONSENT
Localized High-Impact Cryotherapy Services

To enable us to ensure your comfort and safety in all services we provide, please, take time to carefully read this form and answer ALL QUESTIONS to your best ability. All provided information is CONFIDENTIAL and protected – we will never share it with any 3rd parties unless required by law.

Introduction: What is Localized High Impact Cryotherapy?

FrostFit Cryo uses advanced localized cryotherapy technology (**SUBZERO** by **AMERICRYO**) to deliver carbon dioxide (CO2) vapor at -108°F and up to 50 bar pressure to specific areas of the body. This non-medical treatment provides rapid, deep cooling to stimulate pain relief, accelerate recovery, reduce fat deposits and cellulite, and enhance skin firmness and appearance by triggering thermal shock and improving circulation. Localized cryotherapy is safe for most people, but not for everyone, and negative side effects are possible. Familiarizing yourself with this information will help you avoid unwanted consequences.

Tell us about your goals and history of health conditions

First name: _____ Last name: _____

Date of birth: ____ (M) _____ (D) _____ (Y)

Cell #: _____

Email: _____

Emergency contact name: _____

Emergency contact number: _____

How did you hear about us?

____ Word of mouth ____ Facebook ____ Instagram

____ Search engine ____ Influencer ____Other: _____

What is the main goal that you would like us to help you achieve?

____ Post-injury or post-surgery RECOVERY

____ Athletic RECOVERY

____ PAIN relief

____ Firming, toning, tightening of the SKIN in select parts of the body

____ Lessening of FAT deposits

____ CELLULITE reduction

____ Anti-AGING

____ DOUBLE CHIN reduction

____ Management of a SKIN CONDITION

____ Other. Please, specify: _____

Are you pregnant?	____(Y)	_____(N)
Do you have any cold-induced conditions, such as cold hemolysis, cryoglobulinemia, cold agglutination, cold allergies, or other?	____(Y)	_____(N)
Are you hyper- or hyposensitive to cold?	____(Y)	_____(N)
Do you have a trophic disorder?	____(Y)	_____(N)
Do you have any sensory processing disorder?	____(Y)	_____(N)
Do you suffer from polyneuropathy?	____(Y)	_____(N)
Do you have a deficient kidney or liver function?	____(Y)	_____(N)
Do you have an impaired lymphatic system?	____(Y)	_____(N)
Do you have vasculitis (inflamed blood vessel walls)?	____(Y)	_____(N)
Do you have diabetes-related microvascular issues?	____(Y)	_____(N)
Do you have impaired arterial blood flow?	____(Y)	_____(N)
Do you have chronic venous insufficiency?	____(Y)	_____(N)
Do you have a blood disorder related to coagulation?	____(Y)	_____(N)
Do you have cancer or undiagnosed lumps?	____(Y)	_____(N)
In or around the intended treatment area:		
Have you had Botox or fillers in the last 2 weeks?	____(Y)	_____(N)
Have you had any recent skin-sensitizing treatments?	____(Y)	_____(N)
Do you have any open wounds or lesions?	____(Y)	_____(N)
Is your skin sunburn or frostbitten?	____(Y)	_____(N)

Please note that this list is **not exhaustive** - if you have any current injury, illness, serious medical condition, or a health-related concern, that must be brought to our attention in advance of the provision of any services, and in all cases, we recommend consulting a physician prior to using localized high impact cryotherapy.

******* Positively identifying the presence of any of the conditions noted in Part I, above will require you to use discretion for your own well-being. Cold applications can feel slightly uncomfortable and leave the skin pink for a short period following the session, while the skin temperature is returning to normal, but there is no damage, and no recovery required. In case of experiencing burning sensation, pain, or significant discomfort at any time during our treatments, we strongly advise you to terminate the session immediately upon your own volition.

Localized high impact cryotherapy for pain management

We use a high-pressure flow of gasiform CO_2 to lower the tissue temperature in the treated area. The process called cryostimulation causes constriction of the blood vessels in response to cold, followed by dilation and improved blood flow post-treatment, reducing inflammation and swelling and stimulating release of hormones like noradrenaline and Beta-Endorphins which are powerful natural pain killers. Applications include athletic recovery, recovery from soft tissue, muscle, tendon, or overuse injuries or surgery, and painful motion-limiting medical conditions. This treatment does not impose health risks but **should NOT be applied** to highly sensitive skin or open wounds and should be avoided in case of cold allergies or any other cold-induced condition.

Localized high impact cryotherapy for fat freezing/ body sculpting

In this process, we use a phenomenon called cryolipolysis. Cooling the problem areas to the point when subcutaneous fat cells that are very sensitive to low temperatures get damaged and die leads to gradual slimming. Post-treatment, the body uses the lymphatic system to permanently expel the damaged cells.

Because of the strain that the need to eliminate the cellular debris puts on the body, you **should NOT do** fat freezing treatments if you are pregnant, undergoing dialysis, having only one kidney or any type of kidney or liver disease, or impaired circulatory system. Being oversensitive or allergic to cold, having active cancer, or going through chemotherapy are also contraindicated.

High impact cryo facials

Cold applied to the face, neck, or decolletage causes blood vessels to constrict, then dilate, improving circulation and making the skin look firmer and better toned. The process also soothes inflammation, helps fight bacterial infections like acne and stimulates collagen production that has anti-aging effect.

You **should NOT use** cold if you are cold-intolerant or your skin is highly sensitized by sun or treatments like chemical peels. You should take a 2-week break after procedures like Botox or fillers.

LIABILITY WAIVER

In consideration of using the localized cryotherapy services offered by **Arctic Essence, LLC d/b/a FrostFit Cryo (hereinafter "FrostFit Cryo")** and by filling out and signing this Intake Form prior to or during your first visit, you have acknowledged the following:

1. You have been truthful in disclosing your current health condition, as well as past health-related events, including but not limited the ones listed as definite contraindications.
2. You understand that the services provided by **FrostFit Cryo**, although they may have certain health benefits, have been designed to enhance health, appearance and vitality in generally healthy individuals. You have been advised that all services have contraindications and that you should ONLY use any treatments if you don't have the related risks or have discussed them with your doctor and obtained their written consent.
3. You recognize the importance of informing **FrostFit Cryo** personnel about any changes in your health condition, including pregnancy, as they may compromise the effectiveness and/or safety of the services you will receive.
4. You are aware of the need to postpone your appointments with **FrostFit Cryo** if you are feeling sick and have symptoms like fever, congestion, cough, shortness of breath, chest pain, dizziness, nausea, rash, or if you get an acute infection of any kind. The cancellation requirements and package expiration dates still apply.
5. You have been informed that results, especially when it comes to fat loss, cellulite, or aging, are not always immediate, and some benefits will continue to develop over weeks, or even months, post-treatment. Because your body and lifestyle are unique, so will be your progress. In some cases, treatment may not be successful, especially if you fail to follow treatment number and frequency recommendations given to you by **FrostFit Cryo** staff. Commitment to minimum of 6 sessions followed by a proper maintenance protocol is paramount for success.
6. You consent to being committed to promptly following all safety and other behavior- and treatment-related instructions posted through the studio or given to you by **FrostFit Cryo** personnel.
7. You accept the responsibility to immediately inform **FrostFit Cryo** if you feel discomfort or experience any adverse effects from any treatment you are undergoing, as they may indicate the need to discontinue the service.
8. You confirm that you have been explained and understand the administration of the localized high impact cryotherapy services provided by **FrostFit Cryo**, including possible adverse reactions, side effects, or complications. They are rare, but, when extreme cold is involved, minor frostbites may occur and may lead to long-term sensitivity of the affected area to heat or cold post-event.

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** , its agents, assigns, representatives, employees, officers, managers, directors and owners HARMLESS from any consequences and related costs that may incur due to your use of any of the treatments.

You further 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 diet, lifestyle choices and numerous other factors outside **FrostFit Cryo's** control.

CONSENT TO USE PHOTOGRAPHS

Except for pain management, clinical photographs play a key role in monitoring your progress over the weeks of treatment and education of our staff. They also help inform equipment suppliers in the process of continuous development of new applications and better technologies.

Different types of consent are required according to the way in which clinical images will be used. Please **CHOOSE ONE** of the below. If you do not fully understand what each option implies, please ask. Please note that we must take photographs to monitor your progress; so, at least the lowest level of consent (case notes) is REQUIRED.

Your choice of consent level will not affect your treatment in any way.

_____ CONSENT TO OPEN PUBLICATION. I give my consent to **anonymous** publication of my progress images 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 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.

AUTHORIZATION, WAIVER, AND CONSENT

I am: _____ the client _____ a parent/legal guardian of the client under 18

I hereby confirm that all information provided by me herein is correct to the best of my knowledge, and I have disclosed all health-related risk factors that I know of. I understand that treatment safety may depend on my health status.

By signing this document, I CONFIRM THAT I HAVE READ, UNDERSTOOD AND AGREED with the treatment-related risks, liability waiver, and provisions of the **FrostFit Cryo** Service Terms and Conditions.

By signing this document, I ALSO CONFIRM THAT I HAVE BEEN EXPLAINED AND AGREE with the choice of consent level related to the use of the "before" and "after" photographs.

I am aware that, to withdraw my earlier given consent that I could do any time without any impact on the services I will be receiving, I must request it in writing.

Print Name:_____
Signature:_____ Date: _____