Cryotherapy Consent, Release, and Indemnity Agreement

adoRN Esthetics, LLC utilizes Cryotherapy to safely and effectively destroy fat cells without any damage to the skin. The Cryotherapy breaks down fat cells, which your body naturally flushes out through the bloodstream and then the lymphatic system in the days to weeks following the session. Cryotherapy also helps to reduce the appearance of cellulite, fine lines, and wrinkles by stimulating collagen and elastin production while tightening muscles. Cryotherapy is also beneficial for facial toning and lifting. Protocols will be discussed and/or adjusted during consultation based on recommendations and patient needs.
Initial: ______

I understand that results may vary depending on individual factors including but not limited to medical history, prior treatments of area being treated, skin type, medication, hormones, patient compliance with pre/post session instructions and individual response to treatment. I understand that I must maintain good dietary habits, have sufficient water intake, and participate in light physical activity as well as comply with other items outlined during consultation.
Initial: ______

Photos will be obtained for records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed, unless the Cryotherapy treatment is done on the face. We only use the facial photo with your permission.
Initial: ______

The completed form is for informational purposes only. adoRN Esthetics, LLC, we hold the highest standards of safety, customer service and education. The Cryotherapy products and equipment have not been tested or proved by the FDA or any other government agency for the treatment of any illness or disease. Use at your own risk.
Initial: ______

Please initial on the designated lines below:
Body Cryotherapy Contraindications
• Severe Raynaud's
• Severe Allergy to Cold
• Progressive Diseases (MS, ALS, Parkinson's, Neuropathy) • Active Cancer
• HIV/AIDS
• Lymphatic Disorders
• Uncontrolled Diabetes or Diabetes-related complications • Severe Kidney or Liver Disease
• Pregnancy/Breastfeeding/IVF
• Bacterial and viral infections of the skin
• Wound healing disorders
• Circulatory disorders
• Surgery in the past 6 months
• Pacemaker/metal implants
• Active/Severe Eczema, rashes, or dermatitis
• Use of topical antibiotics in desired treatment area
• Silicone/other implants in desired treatment area
• Mesh inserts in the desired treatment area
• Irremovable body piercings in the desired treatment area • Incision scar(s) in the desired treatment area

*I have read and acknowledge that I do not have any of the contraindications to receiving Body **Cryotherapy. Initial: ______**

Facial Cryotherapy Contraindications:
• Severe Raynaud's
• Severe Allergy to Cold
• Progressive Diseases (MS, ALS, Parkinson's, Neuropathy) • Botox in the past 30 days
• Fillers in the past 90 days
• Bacterial and viral infections of the skin
• Wound healing disorders
• Circulatory disorders
• Metal implants
• Surgery in the past 6 months
• Active/Severe Eczema, rashes, or dermatitis
• Silicone/other implants in desired treatment area
• Use of topical antibiotics in desired treatment area
• Irremovable body piercings in the desired treatment area
*I have read and acknowledge that I do not have any of the contraindications to receiving Facial **Cryotherapy. Initial: ______**

The statements above are factual to my knowledge. I understand that any procedure involves risk. Risks may include redness, swelling, irritation, skin reaction, or increased heart rate. Some may experience delays onset muscle soreness from treatments on the stomach due to unintentionally engaging the abdominals, which disappear later the same day. I understand that each person has a different reaction to Cryotherapy. The risks, benefits, and possible results have been explained to me. I have been provided the opportunity to ask questions and receive satisfactory responses.
Initial: ______

I agree to have my photograph taken to document my results. I give permission for any photographs and other audio-visual and/or graphic materials to be used for marketing, education, and/or promotional purposes without any payment to me. I understand that although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I might be identified by the photos.
Initial: ______
By signing below, I ____, acknowledge and certify that I have read and understand the "Consent, Release and Indemnity" agreement for this treatment, and that I am signing it voluntarily. Should any pain or discomfort occur, I will immediately notify the technician. I understand that I must be at least 18 years old to participate in this treatment. I understand that all sales are final and refunds are not permitted.
Printed Name: _______________________________________
Signature: ____
Date: ____
Technician: ____