REJUUV WELLNESS

Client Waiver

Client's Name: _____DOB: _____Gender: _____

Address: _____

Main Contact Number: _____

Email: _____

Reason for Visit: _____

Service(s) are you here for: _____

Expected outcome from these services: _____

Pain level before visit (**1** *no pain – **10** *worst pain ever) _____ After treatment _____

Please tell us how you heard about us? _____

Please circle all conditions you have:

☐Cardiac Arrest	☐Pacemaker	☐Heart bypass/valvular disease
☐Congestive Heart Failure	☐COPD	☐Intrathecal pain pump
☐Electric Stimulation implant	☐Kidney Issues	☐Blood Disorders
☐History of Seizure Disorder	☐Circulatory dysfunction/DVT	☐Skin Disorder/Condition
☐Open wounds/sores/healing disorder	☐Cortisone/Steroid Injection	☐Taking Photosensitive drugs
☐Raynaud's Syndrome	☐Diabetes	☐Migraines
☐Vertigo	☐ Pregnant/Breastfeeding	

Are you currently under the influence of drugs/alcohol? Y N

Please list current medications: _____

Emergency Contact: _____Relationship: _____

Contact Phone Number: _____

Office Use Only: *Follow up call made by: _____Date: _____

Client comments: _____

Conversion: Membership Sessions

WAIVER AND RELEASE AGREEMENT

PLEASE READ CAREFULLY BEFORE SIGNING

Physical Capability Requirements

Participation in some services involve exposure to extreme cold temperature for a short period of time (not to exceed three and one-half (3:30) minutes per session).

LIABILITY AND MEDICAL RELEASE AND INDEMNIFICATION AGREEMENT

In consideration of being permitted by Rejuuv Wellness to participate in their services, I hereby waive all claims and damages for personal injury or death which may occur because of my participation. I understand and agree that:

1. This release is intended to discharge in advance Rejuuv Wellness, 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 result not only because 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. Knowing the risks involved and the contraindications related, I nevertheless chose voluntarily to request permission to participate.
4. I will indemnify and hold harmless Rejuuv Wellness, 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 and agree that this release is intended to be as broad and inclusive as permitted under the law of the State in which it is executed 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.

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 REJUUV WELLNESS. I VOLUNTARILY AGREE TO EACH OF THE TERMS AND PROVISIONS HEREIN AND SIGN THIS OF MY OWN FREE WILL. I AGREE TO COMPLY WITH ALL INSTRUCTIONS FROM REJUUV WELLNESS REGARDING SAFETY AND TECHNIQUE WHEN USING EQUIPMENT AND RECEIVING SERVICES.

CLIENT SIGNATURE: _____DATE: _____

If under 18 years of age, parental consent is required. Separate additional consent form available at the front desk. Customers are required to be a minimum of eleven (11) years of age and between the ages of eleven (11) and fourteen (14) must be accompanied by an adult for use of the whole-body cryotherapy chamber

PARENT/GUARDIAN SIGNATURE: _____DATE: _____

PHYSICIAN'S APPROVAL (IF REQUIRED)

Client can participate on all services being requested: **Yes**_____**No** _____except for: _____

Additional Physician Comments:

Visit www.rejuuv.net/waiver for more information **PHYSICIAN NAME:** _____

Physician Signature: _____DATE: _____