CryoSkin - Client Waiver

PLEASE PRINT LEGIBLY. YOUR INFORMATION IS CONFIDENTIAL

Name: _____Date of Birth:_____ Age: _____

Address: _____

City: _____State: _____ Zip Code: _____

Email Address: _____ Cell Phone: _____

Referred by: _____

In case of emergency, please notify:

Name: _____ Relationship: _____

Address: _____

City: _____State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Elite Wellness
1200 Old Skokie Valley Rd, Highland Park, Illinois 60035 847.748.8804
www.elitestw.com

CryoSkin - Client Waiver

By engaging Elite Wellness, LLC to provide Cryoskin Toning and Slimming ("Services") and using the Company's equipment and facilities in relation thereto, I hereby acknowledge on behalf of myself, my heirs, personal representatives and/or assigns, that there are certain inherent risks and dangers associated with receiving Services and my use of the Company's equipment and facilities. At all times, I shall comply with all stated and customary terms, posted safety signs, rules, and verbal instructions given to me by staff. If in the subjective opinion of the Company's staff, I would be at physical risk in receiving Services, I understand and agree that I may be denied access to Services until I furnish the Company with an opinion letter from my medical doctor, at my sole cost and expense, specifically addressing the Company's concerns and stating that the Company's concerns are unfounded.

I hereby (1) agree to assume full responsibility for any and all injuries or damage which are sustained or aggravated by me in relation to my receiving of the Services, (2) release, indemnify, and hold harmless the Company, its direct and indirect parent, subsidiary affiliate entities, and each of their respective officers, directors, members, employees, representatives and agents, and each of their respective successors and assigns and all others, from any and all responsibility, claims, actions, suits, procedures, costs, expenses, damages, and liabilities to the fullest extent allowed by law arising out of or in any way related to the Services, and (3) represent that: (a) I have no medical or physical condition that would prevent me from receiving the Services, (b) I do not have a physical or mental condition that would put me in any physical or medical danger, (c) I have not been instructed by a physician to not receive Services, (d) no warranty or guarantee, or other assurance, has been made to me covering the results of the Services, (e) knowing the risks involved I nevertheless chose to voluntarily request the Services.

There will be no refunds of any fees paid for these services.

My signature below certifies that I have read and understood the terms outlined above and consent to all necessary therapy as determined.

_____ _____

Signature of patient or responsible party Date

_____ _____

Participant Parent or Legal Guardian Signature
If participant is under the age of 18

Elite Wellness
1200 Old Skokie Valley Rd, Highland Park, Illinois 60035 847.748.8804
www.elitestw.com