3 DEGREES™

CONSENT FORM

Consent to our infrared light therapy treatment is conditional upon providing accurate answers to the following questions and signing this agreement. If you have any health concerns, we highly recommend you consult a doctor prior to use.

Name: _____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Cell): _____ Like to receive text/email appointment reminders? ◯

Email: _____

Emergency Contact (Name, Phone, Relationship): _____

How did you hear about us/Who referred you?_____

Which health benefits are you most interested in seeking therapy for? (Check all that apply)

Weight Loss ____ Stress/Relaxation ____ Detoxification ____ Lower Blood Pressure ____ Arthritis ____

Pain Relief ____ Skin Rejuvenation ____ Muscle Relief ____ Immunity Boost ____ Allergies ____

Fibro ____ Depression/Anxiety ____ Post Surgery Recovery ____ Sleeping ____ Preventative Care ____

Please Answer the Following Questions:

1. Are you pregnant? If Yes, how far along? _____	Yes ( )	No ( )
2. Are you taking any medications? Which:_____	Yes ( )	No ( )
3. Have you been diagnosed with Anhidrosis (cannot sweat) or any other condition that may limit or prevent your ability to sweat?	Yes ( )	No ( )
4. Do you have unstable angina (chest pain)?	Yes ( )	No ( )
5. Have you had a recent heart attack? Coronary issues? If so, when_____	Yes ( )	No ( )
6. Do you have severe arterial disease?	Yes ( )	No ( )
7. Have you been diagnosed with any other medical condition? If "yes", which condition? _____	Yes ( )	No ( )
8. Are you under the age of 18?	Yes ( )	No ( )

If you answered "yes" to any of the above questions, have you consulted with your Medical provider or doctor about receiving infrared light therapy? Yes ( ) No ( )

INFRARED LIGHT THERAPY AGREEMENT/ ACKNOWLEDGEMENT

1. The use of drugs, medication or alcohol prior to or during the session may lead to dizziness or unconsciousness. Clients using any medications must consult a physician or pharmacist prior to use.
2. Please consult your physician if you are in doubt regarding your ability to receive infrared light therapy for health reasons.
3. No one under the age of 18 is permitted in our suites or studio unless accompanied by a supervising adult.
4. Discontinue your session if you feel light-headed, dizzy or heat exhaustion.
5. Infrared sessions should be limited to no more than 40 minutes and temperatures must stay below 160 degrees Fahrenheit.
6. Clients using any medications must consult a physician or pharmacist prior to use.
7. Pregnant women are not permitted to receive infrared light therapy in our studios. Excessive body temperatures have the potential for causing fetal damage during the early days of pregnancy.
8. Appointments that are not cancelled 4 hours prior will result in a nominal charge of $49 or one membership session.

I acknowledge and voluntarily assume the risk of injury, accident or death which may arise from exposure to infrared light. I and any of my heirs, executors, representatives, or assigns hereby release 3 DEGREES and its owners, officers, employees and agents (each, a "3 DEGREES Party") from all claims or liabilities arising in connection with my use of the infrared light therapy and from any advice provided by any 3 DEGREES Party. I agree that this Agreement / Acknowledgment is in effect for all sessions and will not expire unless specifically requested by either party. In addition, 3 DEGREES is not responsible for any damage to any personal electronic devices used inside our cabins/suites or personal belongings left in the studio or suite. If you are under the age of 18, a guardian's signature is required.

Signature:_____ Date:_____

Official Use Only:

Staff Entered: _____Date:_____ Staff Checked: _____Date:_____