IN HIS IMAGE DAY SPA, LLC

INFORMED CONSENT TO FAR INFRARED SAUNA AND/OR SO SOUND THERAPY

Please read the following contraindications before you begin Far Infrared Sauna and/or SO Sound Therapy. **If any of the following apply to you** it is recommended that you consult your Primary Health Care Physician to obtain a release form in order to utilize the Far Infrared Sauna and/or So Sound Therapy:

1. Taking prescription or over-the-counter medications.
2. Cardiovascular conditions or problems (hypertension/hypotension), congestive heart failure, impaired coronary circulation or taking medications which might affect blood pressure.
3. Chronic conditions, diseases associated with reduced ability to sweat or perspire. Multiple Sclerosis, Central Nervous System Tumors and Diabetes with Neuropathy are conditions that are associated with impaired sweating.
4. Hemophiliacs - individuals prone to bleeding.
5. An individual who has a fever should not use the sauna until the fever subsides.
6. An individual with insensitivity to heat should not use the sauna.
7. Pregnancy or during Menstruation.
8. Implants such as metal pins, rods, artificial joints or any other surgical implants.
9. Pacemakers
10. Dizziness, fainting spells, narcolepsy or a history of seizures.

According to research, Far Infrared sauna provides a passive cardiovascular conditioning effect. As the body works to cool itself, there is a substantial increase in heart rate, cardiac output and metabolic rate. **Please Note:** effectiveness of the sauna varies from user to user. Because saunas are designed to increase your body temperature and promote sweating in order to eliminate toxins, it is important that you plenty of water and reduce caffeine intake prior to your session. It is equally important that you re-hydrate after a session.

I acknowledge I have read and understand the above information. I consent to the Far Infrared and/or SO Sound treatments offered or recommended to me. I intend this consent to apply to all my present and future treatments.

Patient Signature_____ Witness Signature_____

Dated this _____ day of _____, 20_____