Complete Wellness Quakertown, llc
COVID-19 Waiver

The novel Coronavirus (COVID-19) is extremely contagious and has been declared a global pandemic by the World Health Organization (WHO). Due to the contagious nature of COVID-19, it may be contracted from various sources and has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. Given the current limitations of COVID-19 virus testing, determining who is infected with COVID-19 is exceptionally difficult. The Center for Disease Control (CDC), and many other public health authorities, still recommend practicing social distancing.

I acknowledge that Complete Wellness Quakertown, llc (CW) has implemented preventative measures in an attempt to reduce the spread of COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment. Given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with my session and that CW cannot guarantee that I will not become infected with COVID-19.

In choosing to proceed with this elective modality, I hereby assume the possible risk of infection with COVID-19 and give my express permission to CW to proceed with providing care. (Please initial each of the following.) _____

_____ My treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.

_____ I am opting for an elective modality that may not be urgent or necessary, and I have the option to defer my session to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired session at this time.

_____ Due to the frequency of appointments with clients, the attributes of the virus, and the characteristics of modalities, I may have an elevated risk of contracting COVID-19 simply by being in CW.

_____ I am NOT feeling ill or experiencing any of the following symptoms of COVID-19:
*Fever/Chills
*Shortness of Breath/Difficulty Breathing
*Dry Cough
*Runny Nose
*Sore Throat
*Loss of Taste or Smell

_____ Travel increases my risk of contracting and transmitting COVID-19. I verify that, in the last 14 days, I have NOT traveled to a highly impacted area within the United States or traveled outside of the United States to countries that have been affected by COVID-19.

_____ I have not been exposed to someone with a suspected and/or confirmed case of COVID-19.

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_____ I have not been diagnosed with Covid-19 and do not have an outstanding test awaiting results - positive or negative.

_____ I am following all CDC recommended guidelines as much as possible and limiting my potential exposure to COVID-19.

_____ I have been offered a copy of this consent form.

I knowingly and willingly consent to the services with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic. I have read, or have had read to me, the above COVID-19 risk informed consent to treat and confirm any/all my questions were answered to my satisfaction. I appreciate that it is not possible to consider every possible complication to care. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office. If any of the above circumstances pertaining to COVID-19 including symptoms, travel, testing or possible exposure occur before my next appointment, I will willingly and expediently notify CW of any changes to my health.

I hereby release and agree to hold Complete Wellness Quakertown, llc harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act by CW, or that may otherwise arise in any way in connection with any services received from CW. I understand that this release discharges CW from any liability or claim that I, my heirs, or any personal representatives may have against CW with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from CW. This liability waiver and release extends to CW together with all owners, partners, and employees.

_____ _____

Signature/e-Signature Date