**STATEMENT DISCLAIMER FOR PATIENTS**

**Please take a moment to read and sign the following information:**

\_\_\_\_\_\_\_ I confirm that I have no current symptoms of Covid-19, have not knowingly been in contact with anyone who has Covid-19 or are in self-isolation. I agree to cancel any treatment immediately should any of the above statements change. I understand that I can re-book when I am clear of any infection or period of self-isolation.

\_\_\_\_\_\_\_\_ I understand that because my treatment may involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including Covid-19.

\_\_\_\_\_\_\_ I affirm that I have notified my therapist of all known medical conditions and injuries.

\_\_\_\_\_\_\_ I agree to inform the therapist of any changes in my health and medical condition. I

understand that there shall be no liability on the therapist’s part should I forget to do so.

\_\_\_\_\_\_\_ By signing this release, I hereby waive and release my therapist from any and all liability, relating to the therapy I receive.

**Client name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist:**

I confirm that at the time of this appointment that I have no current symptoms of Covid-19, have not knowingly been in contact with anyone who has Covid-19 or are in self-isolation. Should this change I will contact you to cancel your appointment and will only re-book your appointment when I am clear of any infection or period of self-isolation.

**Therapist signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**