COVID-19 Information & Liability Waiver

Patient / Client Name: _____ Date: _____

COVID-19 Screening:

1. Do you now, or in the last 14 days have you had, any respiratory or flu symptoms, including sore throat, fever, or shortness of breath? Yes ☐ No ☐
2. In the last 14 days have you been in contact with anyone who has had any respiratory or flu symptoms, including sore throat, fever, or shortness of breath? Yes ☐ No ☐
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has COVID-19 like symptoms? Yes ☐ No ☐

COVID-19 Clinic Policies: (Initial for consent)

___I agree to wear a mask at all times while inside Elixir. (Exceptions include: Children under 2yo, those with respiratory conditions that would experience breathing difficulties, and while lying face down for Acupuncture, Chiropractic, or Massage Therapy)

___ I agree to sanitize my hands upon entering and exiting the clinic. Sanitizer will be provided.

Consent for Treatment

I understand that, because Massage Therapy, Acupuncture, Chiropractic, and some aspects of Naturopathic care involve touch and close physical proximity, there may be an elevated risk of disease transmission, including COVID-19. Elixir has implemented diligent protocols to help limit the spread of COVID-19 and be in compliance with all current Health Authority regulations and state laws. Even with these procedures implemented there is no way to completely eliminate the threat of acquiring COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Patient / Client Name (Printed): _____

Patient / Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____