BODY TEMPLE
PHYSICAL THERAPY, INC.

Licensed Physical Therapist
Certified Athletic Trainer
Certified Strength & Conditioning Specialist

Private Physical Therapy Personal Training Yoga Therapy Wellness

COVID-19 WAIVER

By signing this form, I acknowledge that, with respect to services rendered Body Temple Physical Therapy, a California professional corporation, and their employees and agents (collectively "Company"), I understand the following:

Coronavirus (COVID-19) Risks

I understand that I am opting for a non-essential service which is not urgent and may not be medically necessary. I also understand that the novel Coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization and Centers for Disease Control. I further understand that COVID-19 is extremely contagious and is believed to be spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing, wearing a face mask or covering, and frequent washing of hands and surfaces.

I understand that Company has put in place reasonable and preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by proceeding with receiving physical therapy services. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through receiving these services, and I give my express permission for Company to proceed.

I understand that, even if I have been tested for COVID and received a negative test result or positive anti-body test result, the tests in some cases may fail to detect the virus or may produce a false positive antibody. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms, proceeding with receiving services can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before, during, and after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine or self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation or ventilator support, short-term or long-term intubation other potential complications, and the risk of death. In addition, after receiving my services, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for receiving these services.

I have been given the option to defer receiving these services to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with receiving Company's services.

I have carefully read this form, which is printed in English, and acknowledge that English is a language I read and understand, and that I understand the form. I do not feel rushed or impaired, nor am I under the influence of a sedative or sleep-inducing medication.

I accept and agree to all of the terms above. I am free to refuse or withdraw my consent and to discontinue participation in any treatment, service, or research at any time without fear of reprisal against or prejudice to me. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. I may request and receive a copy of this form from Company. If any portion of this form is held invalid, the rest of the document will continue in full force and effect.

Patient (signature required)				
Signature				
Name				
Date		Time		(AM/PM)
Fill out below if someone other than the patient is signing this form.				
Signature				
Name				
Title/Relationship to Patient				
Authority to Sign Document				
Date				
Witness Name (optional)				
Signature				
Date				