COVID-19 RISK INFORMED CONSENT AND WAIVER OF ALL CLAIMS

I understand the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend physical distancing.

I understand even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand 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 the treatment. I understand possible exposure to COVID-19 before/during/after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death.

I recognize Artesia Physical Therapy, LLC. (hereafter referred to as "Clinic") and its staff are monitoring this situation and have put in place 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 virtue of the circumstances, including attending onsite appointments at this Clinic.

I understand the risk of becoming exposed to or infected by COVID-19 at the Clinic may result from the actions, omissions, or negligence of myself and others, including, but not limited to, the Clinic, employees, volunteers, and other patrons. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my attendance at this Clinic (the "Claims"). On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless the Clinic, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the Clinic, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after attendance of appointments at this Clinic.

I have been given the option to defer my treatment to a later date or receive off-site telehealth appointments. I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19. I would like to proceed with my desired treatment inside this Clinic.

_____ _____

Patient or Person Authorized to Sign for Patient Date/Time

I have been offered a copy of this consent and waiver form (patient's initials) _____