COVID-19 In-Person Therapy Session Waiver

All fields marked with * are required.

☐ I knowingly and willingly consent to have in-person occupational, speech and/or physical therapy and treatment services completed during the COVID-19 pandemic. I understand the COVID-19 virus has a long incubation period, during which carriers of the virus may not show symptoms yet may still be highly contagious. That said, the office of Therapy World is exceeding the sanitization guidelines and recommendations from the discipline association boards, the Centers for Disease Control, and the North Carolina and South Carolina State Department of Health and Human Services.

☐ I understand that in-person occupational, speech, and physical therapy is optional during the COVID-19 pandemic and I have the option to continue being seen remotely via telehealth, if I chose.

☐ I understand that, while Therapy World complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, they can make no guarantees.

☐ I understand that the staff at Therapy World are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since the Therapy World office is a place of public accommodation and therapist travel to other patient homes, daycare and/or schools, other persons (including other patients) could be infected, with or without their knowledge.

☐ I understand that Therapy World reserves the right to deny treatment if they feel that providing care would place myself or staff members at risk.

In order to reduce the risk of spreading COVID-19 within this office and/or between individuals, I agree that I will answer the following screening questions truthfully:

* Please answer yes or no to the following:

Have you, or anyone in your household tested positive to COVID-19 in the past fourteen (14) days? ◯ YES ◯ NO

Are you currently awaiting the results of a COVID-19 test? ◯ YES ◯ NO

Have you been exposed to anyone who tested positive to COVID-19 within the past fourteen (14) days? ◯ YES ◯ NO

Have you, or anyone in your household, had any flu-like symptoms (i.e. fever, shortness of breath, cough) and/or experienced rash, new loss of taste or smell in the past fourteen (14) days? ◯ YES ◯ NO

Patient's Name	Patient's Guardian Name	Date

I agree to the terms stated above and that I have answered the screening questions truthfully (Sign Below)

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