

**COVID19 Liability Waiver**

Please print and complete this form and bring it with you.

Name \_\_\_\_\_

Date \_\_\_\_\_

**Consent for Treatment:**

I understand that, because therapeutic bodywork involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID19. 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 therapist/business from any claims related thereto. I give my consent to receive treatment from this therapist.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature (in case of minor) \_\_\_\_\_ Date \_\_\_\_\_