91 Gregory Lane, Suite 13, Pleasant Hill, CA 94523
hello@calmedciti.com | (925)665-0008 | www.calmedciti.com

Patient's Name: _____ Date of Birth: _____

COVID – 19 LIABILITY WAIVER

By completing and submitting this form, you are knowingly and willingly consenting to services performed during the Covid- 19 Pandemic and you agree to adhere to all health and safety protocols.

(Please check-off each box to confirm it has been read)

- ☐ I acknowledge that anytime I am within close proximity (less than 6ft) of my healthcare practitioner, staff, or any other person, I could have an elevated risk of contracting the virus
- ☐ I agree that I will cancel/reschedule my appointment if I am experiencing any Covid – 19 like or respiratory symptoms. Such as, fever, cough, chills, body aches, headaches, sore throat, loss of taste or smell, shortness of breath, or difficulty breathing.
- ☐ I understand that I, nor any members of my household, have not travel in the last 14 days prior to my appointment. If so, I will cancel/reschedule my appointment for later date.
- ☐ I, nor any members for my household, have not been exposed to someone with a suspected and/or a confirmed case with Covid-19. If so, I will cancel/reschedule my appointment for a later date
- ☐ I, nor any member of my household have not been diagnosed with Covid-19 within 14 days. If so I will cancel/reschedule my appointment for a later a date and provide Covid-19 test results.
- ☐ I understand that I am required to wear a face covering or mask during the duration in the office.
- ☐ I understand that when I arrive for my appointment my temperatures will be taken. If I do have a fever, I will be asked to leave the office and will receive a phone call to reschedule my appointment.
- ☐ I understand that this business my healthcare practitioner, staff, or any other person, cannot be held liable for any exposure to the Covid – 19 virus

Our practice is doing everything we can to protect you, your family and our physicians and staff. If we all work together, we can overcome the spread of the virus. By signing below, you agree to comply with the written protocols above. Failure to comply with these written instructions or verbal instructions from the healthcare practitioner or staff may result I your removal from the premises.

I agree by signing below, I am rendering my signature in acknowledge of the statements on this form and all information provided is accurate as of the date of this form.

Patient Name (PLEASE PRINT): _____

Patient Signature: _____ **Date Signed:** _____

Relationship to patient if not signed by patient: _____