COVID-19 TREATMENT WAIVER

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have not shown any signs or symptoms of the COVID 19 VIRUS. Such as: Fever, Coughing, Diarrhea, Shortness of Breath or Flu like Symptoms.\_\_\_\_\_

I have not tested positive in the past 120 days.\_\_\_\_\_

I have not traveled outside the US, NY, CA or WA, New England area states or on a cruise ship in the past 120 days.\_\_\_\_\_

I have not been around anyone that has tested positive for COVID-19.\_\_\_\_\_\_

I am consenting to treatment from service provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I will inform the center and the therapist of any special needs, medical conditions, or changes in my health. All information exchanged during treatment session is confidential and is only used to provide the best treatment possible. If I am having or develop any complications during my service, I will promptly discuss this with my therapist. I hereby voluntarily release Renew Wellness Center, Central Florida Massage Clinics and the Independent Contractor for service from any liability or complications that may occur. By signing below, I agree that I have read the information above and have decided to receive services at my own risk.

Print Name Signature Date