**Waiver of Liability Relating to Coronavirus/COVID-19**

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact and/or by contact with contaminated surfaces and objects, and even possibly in the air. People reportedly can be infected and show no symptoms and therefore spread the disease. The exact methods of spread and contraction are unknown, and there is no known treatment, cure, or vaccine for COVID-19. Evidence has shown that COVID-19 can cause serious and potentially life-threatening illness and even death.

Welsh Therapy and Associates cannot prevent you [or your child(ren)] from becoming exposed to, contracting, or spreading COVID-19 while utilizing in person therapeutic services. It is not possible to prevent against the presence of the disease. Therefore, if you choose to utilize Welsh Therapy and Associates in person services and/or enter onto Welsh Therapy and Associates premises you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19.

**ASSUMPTION OF RISK**: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself and/or my children in order to utilize Welsh Therapy and Associates in person services. These services are of such value to me [and/or to my children,] that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to utilize Welsh Therapy and Associates in person services rather than arranging for an alternative method of enjoying the same services virtually (e.g. Telehealth).

**WAIVER OF LAWSUIT/LIABILITY**: I hereby forever release and waive my right to bring suit against Welsh Therapy and Associates, LPC in connection with exposure, infection, and/or spread of COVID-19 related to utilizing Welsh Therapy and Associates in person services. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

**CHOICE OF LAW**: I understand and agree that the law of the State of Pennsylvania will apply to this contract.

**I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am the parent or legal guardian of the minor named above. I have the legal right to consent to and, by signing

below, I hereby do consent to the terms and conditions of this Release.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notification of Symptoms or Illness/Change of Service Delivery**

**Do you have any of the following?**

* Fever or chills (100.4° F [38.0° C] or greater using an oral thermometer)
* Cough
* Shortness of breath or difficulty breathing
* Fatigue
* Muscle or body aches
* Headache
* New loss of taste or smell
* Sore throat
* Congestion or runny nose
* Nausea or vomiting
* Diarrhea
* Have contact with someone diagnosed with COVID-19
* Visited a place where COVID-19 is spreading

In the event that the client or the counselor should experience a possible exposure or development of the above listed symptoms, we agree to immediately notify the other and agree to modify or halt therapy until it is safe to resume.  This may include a change in meeting place, moving the sessions to an online platform utilizing telehealth, or utilization of phone/text messages to maintain connection while the individual is recovering.

**I have read and understand the information presented above and I agree to notify the individual (client/counselor) should I believe that I have been exposed to or have developed symptoms related to COVID-19:**

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

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_