COVID-19 CONSENT

First Name: ______________________ Last Name: ______________________

Appointment Date: ______________________

I willingly consent to having service(s) or treatment(s) during the COVID-19 pandemic.

❑ By checking this box I understand and accept this statement.

To prevent the spread of contagious viruses and to help protect each other, I understand that I must follow the strict guidelines of the medical spa.

❑ By checking this box I understand and accept this statement.

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have not traveled out of country in the last 14 days.

❑ By checking this box I understand and accept this statement.

I understand that there is increased risk of spreading/contracting COVID-19 due to the frequency of patient visits, the requirements of medical spa services, and the characteristics of the virus itself.

❑ By checking this box I understand and accept this statement.

I understand that without proper testing you cannot determine who has the COVID-19 virus and who doesn't. The virus has a long incubation period during which carriers may not show symptoms, but may still be highly contagious.

❑ By checking this box I understand and accept this statement.

Have you traveled internationally via commercial airline, bus or train within the past 14 days?

❑ yes ❑ no

Have you traveled domestically via commercial airline, bus or train within the past 14 days?

❑ yes ❑ no

I have followed the recommendations of my local health authority regarding COVID-19 rules.

❑ yes ❑ no

I am willing to take a temperature check immediately prior to my treatment.

❑ yes ❑ no

I understand that this establishment and its staff have the right to refuse treatment if I display any of the following symptoms; fever, cough, loss of taste or smell, shortness of breath, difficulty breathing, sore throat or runny nose.

❑ By checking this box I understand and accept this statement.

I have read, understood, and completed this questionnaire truthfully. I agree that this constitutes full disclosure and that it supercedes any previous verbal or written disclosures.

❑ yes ❑ no

Patient Signature:______________________ **Date:** ______________________

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