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**81 Middlecote Drive. Ajax, Ontario. L1T 0K3**

**P: (905) 231-1418 F: (905) 448-2538**

[**www.reactivatephysiotherapy.com**](http://www.reactivatephysiotherapy.com)

[**reactivatephysio@hotmail.com**](mailto:reactivatephysio@hotmail.com)

**COVID-19 Liability Waiver**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that physiotherapy and massage therapy services may require hands on contact which is one way the novel coronavirus can spread. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Initial)

I understand that being out in the community and attending visits at Reactivate Physiotherapy & Massage puts me at an elevated risk of contracting the novel coronavirus when compared to at home isolation. \_\_\_\_\_\_\_\_\_\_\_\_\_ (Initial)

I confirm that I am not presenting with any of the following symptoms of COVID-19 as defined by the Ministry of Health of Ontario:

* Fever >38° \_\_\_\_\_\_\_\_\_\_\_\_ (Initial)
* Cough \_\_\_\_\_\_\_\_\_\_\_\_ (Initial)
* Sore Throat \_\_\_\_\_\_\_\_\_\_\_\_ (Initial)
* Shortness of Breath \_\_\_\_\_\_\_\_\_\_\_\_ (Initial)
* Difficulty Breathing \_\_\_\_\_\_\_\_\_\_\_\_ (Initial)
* Flu-Like Symptoms \_\_\_\_\_\_\_\_\_\_\_\_ (Initial)
* Runny Nose \_\_\_\_\_\_\_\_\_\_\_\_ (initial)

I confirm that I am not currently positive for the novel coronavirus. \_\_\_\_\_\_\_\_\_\_\_\_ (Initial)

I confirm that I have not been in contact with someone who has tested positive for coronavirus. \_\_\_\_\_\_\_\_\_\_\_(Initial)

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. \_\_\_\_\_\_\_\_\_\_\_(Initial)

I understand that it is not possible to receive in person physiotherapy and massage therapy services while maintaining the 6 feet social distancing as per the recommendations of the Ministry of Health of Ontario. \_\_\_\_\_\_\_\_\_\_\_(Initial)

I verify the information I have provided is truthful and accurate. I knowingly consent to in-person treatment during the COVID-19 pandemic.

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

Patient Signature