COVID-19 Pandemic
Colonics with Care Treatment Consent Form

Please take a moment to complete our consent form.
Bring this with you to your appointment. By submitting the form you agree to knowingly and willingly consenting to have a Colonic treatment during the COVID-19 pandemic.
We reserve the right to refuse service if this form is not submitted. Thank you.

First Name: ______________________ Last Name: ______________________Date: ___________

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing. ☐ **Yes** ☐ **No**

I understand that due to the frequency of visits of other clients, the characteristics of the virus, and the characteristics of Colonic services, that I have an elevated risk of contracting the virus simply by being in the office. ☐ **Yes** ☐ **No**

I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below:
• Temperature above 98.7 degrees • Shortness of breath • Loss of sense of taste or smell • Dry cough • Sore Throat ☐ **I Am Not Presenting Symptoms**

I confirm that I have not been around anyone with these symptoms in the past 14 days.
☐ **Yes** ☐ **No**

I do not live with anyone who is sick or quarantined. ☐ **Yes** ☐ **No**

To prevent the spread of contagious viruses and to help protect each other, I understand that I will have to follow the office's strict guidelines. ☐ **Yes** ☐ **No**

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And I understand that the CDC, and OSHA recommend social distancing of at least 6 feet. ☐ **Yes** ☐ **No**

I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. ☐ **Yes** ☐ **No**

I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. ☐ **Yes** ☐ **No**

By signing below, I hereby release and agree to hold Colonics with Care harmless from and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses, and compensation for damages or loss to myself and/or property that may be caused by any act, or failure to act of the office, or that may otherwise arise in any way in connection with any services received from Colonics with Care. I agree to release Colonics with Care from any and all liability for the unintentional exposure or harm due to the Coronavirus (COVID-19)

Please sign full name below. By signing and submitting, this verifies that you fully agree to our safety policy for our services.

Signature: ____ Date: ______________________