SERENDIPITY
WELLNESS STUDIO

COVID-19 Pre-treatment health questionnaire

Name: _____ date of appt: _____

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ○ No ○

2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes ○ No ○

3. Do you now, or have you recently had, any chills, muscle aches, new loss of taste or smell, or new rashes or lesions? Yes ○ No ○

4. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ○ No ○

Consent for Treatment:
To proceed with receiving care, I confirm and understand the following (Initial in all places provided)

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associate with receiving care during the COVID19 pandemic. I have read the above COVID 19 risk informed consent to treat. I appreciate that it is not possible to consider every possible complication to care. I understand that, because massage therapy/esthetics involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/Serendipity Wellness Studio,Inc. from any claims related thereto. I give my consent to receive treatment from Serendipity Wellness Studio and my assigned practitioner.

If you have answered yes to any of the above questions, please call 571-217-1150 to reschedule your appointment for when you can answer NO to all questions and at least 14 days from today.

If you answered NO to all the questions…YEAH! We look forward to seeing you for your appointment.

signature:_____date: _____