



Informed Consent:

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO) and that COVID-19 is extremely contagious and may be contracted from various sources. I understand that COVID-19 has a lengthy 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. Part of Elizabeth Rogers Pilates & Physical Therapy, PLLC's role is to provide me with information to assist me in making informed choices. By coming to Elizabeth Rogers Pilates & Physical Therapy, PLLC's clinics/studios (Mount Baker and/or Ravenna locations) to receive physical therapy services and/or Pilates instruction, I understand that there are associated risks for contracting COVID-19. Given the current limitations of COVID-19 testing, I understand that determining who is infected with COVID-19 is exceptionally difficult.

To proceed with participation in physical therapy and/or Pilates services, I confirm and understand the following:

1. I have read and understand Elizabeth Rogers Pilates & Physical Therapy, PLLC's Covid-19 Exposure Control, Mitigation and Recovery Plan.
2. **I will wear my own mask. If I fail to bring a mask, I will be required to pay \$5 for a mask or pay the \$65 late cancellation fee or cost of a Pilates session.** The \$5 mask fee (minus CC fees) will be donated to charity.
3. Working with my physical therapist and/or Pilates instructor may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.
4. Due to the attributes of the virus, I may have an elevated risk of contracting COVID-19 simply by being in the clinic/studio.
5. I have been given the opportunity to access services virtually or postpone services, but I have opted for in-person services. I will contact Elizabeth Rogers if my circumstances change, if I become infected or have emergent health and safety needs.
6. I will wear a mask while at Elizabeth Rogers Pilates & Physical Therapy, PLLC.
7. **I will not enter the clinic/studio until a team member has screened me and invited me in. Clients who are sent home due to screening results, will be charged \$65 late cancel fee or cost of a Pilates session. Therefore, all patients should do self assessment daily, so that they may give 24 hours notice for cancellation.**
8. I will follow all symptom assessment, hygiene/cleaning, PPE and social distancing protocols mandated by relevant health authorities and Elizabeth Rogers Pilates & Physical Therapy, PLLC to the best of my ability.
9. I confirm that if I am experiencing symptoms of COVID-19, I will cancel all appointments.
10. If I, or someone I live with, care for/have contact with is diagnosed with COVID-19, I will follow all health department recommendations and contact Elizabeth Rogers immediately at 206-535-7356 to inform her of this exposure.
11. I understand that travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days travelled by plane, train or cruise ship. I will wait 14 days to return to the clinic/studio following travel by plane, train or cruise ship.

I knowingly and willingly consent to the above terms in order to enter and receive physical therapy care and/or Pilates instruction at Elizabeth Rogers Pilates & Physical Therapy, PLLC's Mount Baker and/or Ravenna locations. I agree to all State of Washington and locally mandated symptom assessment, cleaning/hygiene, social distancing and PPE directives outlined in the company's Covid-19 Exposure Control, Mitigation and Recovery Plan. I confirm all of my questions were answered to my satisfaction.

Client Signature _____ Date _____

Printed Name _____