COVID-19 Day of Treatment State of Health Statement

Decatur Healing Arts; 619B or 627H East College Ave; Decatur, GA 30030

DATE: ________________

By signing below: Client and Therapist agree to take full responsibility for their own actions and safety and to be in compliance with the following.

- I have not been in knowing contact with anyone known to have COVID-19 within 14 days of this appointment.
- I am not currently experiencing any of the symptoms of COVID-19 as outlined by the CDC (including cough, shortness of breath, difficulty breathing, or at least two of the following symptoms: chills, shaking with chills, muscle pain, headache, sore throat, and loss of taste or smell).
- I will keep a safe distance (6 feet) from others when possible.

Therapist: ___________________________________ Date ________________

Client: _______________________________________Date _________________