
***Voted "Best Physical Therapy Center" by the Myrtle Beach Herald***

## COVID-19 Liability Release Waiver

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that Low Country Physical Therapy has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19. I further acknowledge that Low Country Physical Therapy can not guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, staff, and other Low Country Physical Therapy clients and their families. I voluntarily seek services provided by Low Country Physical Therapy and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:

* I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
* I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non contagious by state or local public health authorities.
* I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Low Country Physical Therapy 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 damage or loss to myself and/or property that may be caused by any act, or failure to act of the facility, or that may otherwise arise in any way in connection with any services received from Low Country Physical Therapy.

Patient Signature: _____ Date: _____/_____/_____

_____ Date: _____/_____/_____

Responsible Party's Signature (if patient is a minor)

"We treat you like family"
2586 South Hwy 17 Business/ Garden City Beach, SC 29576/Tel (843)651-6565/Fax (843)651-6575
267 Willbrook Blvd, Suite D/Pawleys Island, SC 29585/Tel (843)314-3980/ Fax (843)314-3979
www.lowcountrypt.com • lowcountrypt@sc.rr.com