

Assumption of the Risk and Waiver of Liability Relating to  
Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

**Sandra Salazar, her clinical team and administrative staff at Forever Hope Counseling & Educational Services, LLC** have put in place preventative measures to reduce the spread of COVID-19; however, **there is NO guarantee** that you will not become infected with COVID-19. Please be aware that, by **attending your counseling session in person**, your risk of contracting COVID-19 may increase.

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By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by attending my counseling session(s) in person and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I also understand that the risk of becoming exposed to or infected by COVID-19 by attending in person counseling session(s) may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Sandra Salazar and the clinical and or administrative team or others at **Forever Hope Counseling & Educational Services, LLC**.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my attendance at the **Forever Hope Counseling & Educational Services, LLC** offices for participation in the counseling session ("Claims"). On my behalf, and on behalf of anyone claiming through me, I hereby release, covenant not to sue, discharge, and hold harmless Sandra Salazar and **Forever Hope Counseling & Educational Services, LLC**, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto.

I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Sandra Salazar, and **Forever Hope Counseling & Educational Services, LLC**, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any counseling services or program.

\_\_\_\_\_  
\_\_\_\_\_  
**Signature of Client(s)**

\_\_\_\_\_  
\_\_\_\_\_  
**Date**

## COVID-19 Visitor Questionnaire

The safety of our employees, partners, customers, families and visitors remain the Groups' overriding priority. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing. To prevent the spread of COVID-19 and reduce the potential risk of exposure to our workforce and visitors, we are conducting a simple screening questionnaire.

Your participation is important to help us take precautionary measures to protect you and everyone in this building. Our staff and clinical team thank you for your honesty and cooperation!

You may be asked to complete this form again.

Visitor's Name:	Personal Phone Number (mobile/home)
Visitor's Company/Organization:	Name of Group Host:

Self-Declaration by Visitor	
1	Have you been diagnosed with or exposed to anyone diagnosed with COVID-19 / coronavirus?  <input type="checkbox"/> YES <input type="checkbox"/> NO
2	Do you have reason to believe that you, or someone in your household or someone who you have been in close contact with, has been exposed to COVID-19/coronavirus?  <input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you or anyone in your household traveled out of state or abroad in the last 14 days?  <input type="checkbox"/> YES <input type="checkbox"/> NO
4	Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, difficulty breathing)?  <input type="checkbox"/> YES <input type="checkbox"/> NO

If the answer is "yes" to any of the questions, we will be unable to grant you access to the facility until further notice. Please update our office of any changes to your answers for the duration of your treatment.

Signature (visitor): \_\_\_\_\_ Date: \_\_\_\_\_

Clinician or Administrator: \_\_\_\_\_