William James Brooks, DO, PC
Board Certified - Osteopathic Manipulative Medicine

Infectious Disease Waiver and Release

William James Brooks, DO, PC/dba Restorative Care Clinic and William Brooks, DO and his staff are committed to the health and safety of its/his patients and intends to continue to offer its'/his services unless and until prohibited from doing so by governmental order or other circumstances. It/he strive(s) to ensure cleanliness and minimize the risk of spread of infectious disease, including but not limited to the coronavirus that causes COVID-19, throughout its'/his administrative and clinical rooms.

It/he recognize that all mechanisms of the spread of infectious disease may not be known and understand that a patient may become infected as a result of exposure on its'/his premises in spite of its'/his best efforts to mitigate the spread of infectious disease. Accordingly, a patient who wishes to receive care at its'/his office in light of these risks is requested to sign this waiver, acknowledging the possibility of contracting infection in its'/his office and waiving any claims against William James Brooks, DO, PC/dba Restorative Care Clinic and William Brooks, DO and his staff.

Please initial the following statements to indicate your agreement with and adoption of each statement.

_____I am aware that, should I be unwilling to assume the risks of contracting infectious disease on the premises of William James Brooks, DO, PC/dba Restorative Care Clinic and William Brooks, DO, I have the right to cancel my appointment and that cancellation fees will be waived for this appointment.

_____I understand that it is possible that I may contract an infectious disease, including but not limited to the coronavirus that causes COVID-19, on the premises of William James Brooks, DO, PC/dba Restorative Care Clinic and William Brooks, DO. I knowingly and intentionally accept the risk of such infection.

_____I hereby release William James Brooks, DO, PC/dba Restorative Care Clinic and William Brooks, DO and his staff from any and all responsibility from any and all ill effects of infectious disease that may result from my decision to receive examination and treatment from William Brooks, DO and his staff.

_____I certify that I have read and understand this waiver and release and that I sign the same as my free and informed act.

Executed on _____by Patient (Patient Representative) _____

Print Patient Name _____

and by William James Brooks, DO, PC_____
James C Brooks, Secretary or William Brooks, DO, President, William James Brooks, DO, PC

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