PARK CITIES PSYCHIATRY, LLC
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PARKCITIESPSYCH.COM
Regina McFarland, M.D. Sandra Lotan, M.D.

WAIVER AND RELEASE OF LIABILITY

PATIENT NAME: _____

Patient Parent/Guardian Name (if under 18):_____

The novel coronavirus commonly known as COVID-19 (the "Virus") has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the Virus is believed to spread from person-to-person contact and/or by contact with contaminated surfaces and objects, and even possibly in the air. People reportedly can be infected and show no symptoms and therefore spread the disease. There is no known treatment, cure, or vaccine for the Virus. **Evidence has shown that the Virus can cause serious and potentially life threatening illness and even death.**

I, _____ (or if under 18 years old, parent or other legally responsible adult, acting on the minor's behalf), have voluntarily decided or requested to attend an appointment on the premises in the office at Park Cities Psychiatry. I am 18 years of age or older, of sound mind, and understand and agree to the terms of this Waiver and Release of Liability (the "Waiver"). I have been afforded the opportunity to review the contents of this Waiver with an attorney of my choosing if I believed it was necessary to do so.

I understand and acknowledge that being present for an appointment on the premises at Park Cities Psychiatry may expose me to contact with one or more persons who have been infected with, and/or exposed to, the Virus. I further understand that my presence on the premises at Park Cities Psychiatry may expose me to contact with surfaces or objects that contain the Virus and may serve as a means for transmission of the Virus to those who have been or are present at Park Cities Psychiatry. Based on the forgoing, I understand that my presence at the offices of Park Cities Psychiatry may expose me, along with others with whom I may come in contact after the appointment, to a risk of infection with the Virus, which may cause significant and serious illness, bodily injury, disfigurement, temporary or permanent disability, and/or death. I understand that personal protective equipment ("PPE") designed to reduce the chances of exposure to or infection with the Virus may not be readily available or provided for me at Park Cities Psychiatry, and that the use of PPE may in any event not fully protect against or mitigate the risks posed by my presence at the office of Park Cities Psychiatry. I understand and agree that this office may not, and is under no legal duty to, provide me with any PPE.

ASSUMPTION OF RISKS:

I have read and understood the above warning concerning the Virus. I hereby choose to accept the risk of contracting the Virus in order to enter the premises and at Park Cities Psychiatry to participate in my appointment. My participation in person for the appointment is of such value to me that I accept the risk of being exposed to contracting and/or spreading the Virus in order to participate in the appointment in person [if applicable: "rather than arranging for an alternative method of conducting the appointment (e.g. videoconference)"].

WAIVER AND RELEASE OF LIABILITY:

In consideration for the grant of permission by Park Cities Psychiatry for me to attend the appointment at the facilities of Park Cities Psychiatry, I hereby release, indemnify, and hold harmless Park Cities Psychiatry and its agents, employees, officers, and directors (collectively, "Releasees") from all claims for damages of any kind, including, but not limited to, personal injuries, property damage, illness, disability, death, expenses of litigation or settlement, costs of court, and attorneys' fees, arising out of or related in any way to my presence on the premises of Park Cities Psychiatry, **INCLUDING THOSE CLAIMS WHICH ARISE OR ARE ALLEGED TO ARISE FROM THE NEGLIGENCE OF ANY OF THE RELEASEES. THIS RELEASE IS TO BE CONSTRUED AS THE BROADEST FORM OF RELEASE PERMITTED BY APPLICABLE LAW.**

COVENANT NOT TO SUE:

I hereby promise not to sue any of the Releasees for any claims arising out of or related in any way to Park Cities Psychiatry. I understand that this Waiver means that I have contractually agreed not to bring any claims, against any of the Releasees, arising out of a related in any way to the premises or medical practice of Park Cities Psychiatry, **INCLUDING THOSE CLAIMS WHICH ARISE OR ARE ALLEGED TO ARISE FROM THE NEGLIGENCE OF ANY OF THE RELEASEES.**

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS WAIVER, AND AM FREELY AND KNOWINGLY GIVING UP VALUABLE LEGAL RIGHTS AGAINST THE RELEASEES.

Signature:_____Date:_____

Parent/Guardian Signature (if under 18): _____