Advanced Therapeutics
Pain Relief & Wellness Center

visit our website:
yogaandmassage.center
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704-332-7700

Agreement of Release and Waiver of Liability

I, _____, hereby agree to the following:

1. That I am participating in the Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops offered by **Advanced Therapeutics Pain Relief and Wellness Center**, during which I will receive information and instruction about yoga and health. I recognize that fitness training and classes and yoga require physical exertion that may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved.

2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops. I represent and warrant that I am physically fit and I have no medical condition that would prevent my full participation in the Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops.

3. In consideration of being permitted to participate in Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops, I agree to assume full responsibility for any risks, injuries or damages, know or unknown, which I might incur as a result of participating in the programs.

4. In further consideration of being permitted to participate in Fitness, Yoga classes, Health Programs, Massage Therapy or Workshops, I knowingly, voluntarily and expressly waive any claim I may have against **Advanced Therapeutics Pain Relief and Wellness Center** for injury or damages that I may sustain as a result of participating in the programs.

5. I, my heirs or legal representatives forever release waive, discharge and covenant not to sue **Advanced Therapeutics Pain Relief and Wellness Center** for any injury or death caused by my negligence or other acts. I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

6. Do you have a Fever OR Cough OR Shortness of Breath? ☐ YES ☐ NO

If yes, is there another reason for fever? Or at least two of these symptoms: DIARRHEA HEADACHE CHILLS SORE THROAT MUSCLE PAIN NEW LOSS OF TASTE/SMELL REPEATED SHAKING AND CHILLS

In the last 14 days have you had any contact with a COVID-19 positive patient, as far as you know or someone awaiting test results? ☐ YES ☐ NO

Date Signature of Participant

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email
providing your email address allows us to send you specials, coupons and updates. Thank you.

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