

COVID-19 Health Information & Informed Consent

Client Name: _____

Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

COVID-19 Information

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100 degrees or above? YES NO
2. Do you now, or have you recently had any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? YES NO
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? YES NO
4. Have you had a new loss of sense of taste or smell? YES NO

The following questions are specific to a new aspect of COVID-19 involving blood coagulation.

6. Can you exercise to get your heart rate and respiratory rate up without any problem? YES NO
7. Have you had a new onset of muscle aches and pain since the emergence of the virus: YES NO
8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? YES NO

PROCEED TO PAGE 2 FOR MORE

CONSENT FOR TREATMENT

*To proceed with receiving care, I confirm and understand the following (**initial in all places provided**)*

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as “informed consent” and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a space that can be closed (my home office has doors and windows for proper ventilation), there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 INFORMED CONSENT TO FOR TREATMENT. I UNDERSTAND THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POTENTIAL COMPLICATION. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ *Date:* _____

Parent or Guardian Signature (in case of a minor): _____ *Date:* _____