COVID-19 Health Information & Informed Consent

Client Name: _____

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

The client will be asked to answer the following COVID-19 related health questions at each appointment

1. Have you had a fever in the last 24 hours of 100°F or above? Temperature will be taken with a touchless thermometer when you arrive for each appointment.

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)?

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?

4. Have you traveled anywhere outside of the state in the last two weeks? If so, what location?

5. Have you had a new loss of sense of taste or smell?

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 has a long incubation period during which carriers may not show symptoms but still be contagious. _____

I understand that I am the decision maker for my health care. I understand my practitioner will provide me with information regarding exposure risk to the COVID-19 virus so that I may make an informed choice regarding treatment (informed consent). I also understand that it is my responsibility to inform my practioner of my risk of exposure to COVID-19 so that we may both agree to move forward with treatment. _____

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 closed space, 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 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 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. 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 AT HEALING HANDS THERAPEUTIC MASSAGE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE AT THIS ESTABLISHMENT.

Client Signature: _____ Date: _____