



## COVID-19 Health information and 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. To protect your health and the health of others, please read and fill out this form carefully and let me know if you have any questions.

### COVID-19 Health Information

Please answer these COVID-19 health questions below:

1. Have you had a fever of 100°F or above in any given day(s) during the past 14 days?  
Yes  No
2. Have you, in the past 14 days, had any respiratory or flu-like symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes  No
3. Have you had a new loss of sense of taste or smell in the past 14 days? Yes  No
4. Have you seen any new marks, rashes, spots, bumps or other lesions on your skin? Y/N
5. Have you been in contact with any individual in the last 14 days, who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes  No
6. Have you traveled anywhere in the last 14 days via public transportation, such as train, bus and airplane? Yes  No
7. Have you been to places in the last 14 days, which are identified as areas with high infection rate? Y/ N. If yes, where \_\_\_\_\_
8. Have you had direct contact with a confirmed COVID19 patient in the past 14 days?  
Yes / No
9. Have you received COVID vaccination yet? Y?N Are you fully vaccinated with 2 does of CDC recommended shots? Y?N Have you received a booster shot ? Y?N

### 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 during 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. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. \_\_\_\_\_

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 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 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 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: \_\_\_\_\_