COVID-19 INFORMED CONSENT TO TREAT

To proceed with receiving care, I confirm and understand the following as indicated by my initial in all seven places provided:

___I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: **Fever, Dry cough, Sore throat, Shortness of breath, Runny nose, Loss of taste or smell.**

___ I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, iCOVID-19 can be transmitted.

___I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.

___I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have elevated risk of contracting COVID-19 simply by being in a health care office.

___I verify that I have NOT in the past 14 days traveled: 1) Outside of the United Sates to countries that have been affected by Covid-19; or 2) Domestically within the United States by commercial airline, bus or train.

___I am informed that you have implemented preventive measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby and acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you 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 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 CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND TO COVER THE ENTIRE COURSE OF CARE FROM MY PROVIDER, ELAINE WARREN, L. AC., FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature _____ Witness Signature _____

Name _____ Name _____

Date _____ Date _____