COVID-19 INFORMED CONSENT TO TREAT

SUPPLEMENTAL CONSENT FORM – COVID-19 DUE TO THE INFECTIOUS NATURE OF COVID-19, THIS ADDITIONAL INTAKE FORM MUST BE COMPLETED BEFORE EACH ACUPUNCTURE SESSION. PLEASE KNOW THAT PEOPLE WITH COVID-19 CAN BE ASYMPTOMATIC AND STILL BE CONTAGIOUS. THERE IS NO WAY TO COMPLETELY PROTECT OURSELVES FROM THIS VIRUS. PLEASE ANSWER THESE QUESTIONS TRUTHFULLY AND DO EVERYTHING ASKED SO WE CAN DO OUR BEST TO PROTECT EACH OTHER.

THANK YOU

TO PROCEED WITH RECEIVING CARE, I CONFIRM AND UNDERSTAND THE FOLLOWING (INITIAL IN ALL PLACES PROVIDED)

INITIAL BELOW:

_____ I UNDERSTAND, WAIVE AND RELEASE JANIS KRAUSE OF ANY RESPONSIBILITY BOTH LEGALLY AND MONETARILY IN ANY WAY, IN THE EVENT THAT I CONTRACT COVID-19.

_____ I WILL NOT COME IN FOR MY SCHEDULED APPOINTMENT IF I AM EXHIBITING ANY SYMPTOMS OF COVID-19 AS LISTED BY THE GOVERNMENT OF SASKATCHEWAN. I UNDERSTAND THAT IF I AM NOT TRUTHFUL REGARDING MY CURRENT STATE OF HEALTH, IT COULD RESULT IN HARM TO OTHERS AND SUCH ACTIONS WILL BE REPORTED TO THE GOVERNMENT OF SASKATCHEWAN.

_____ I AM INFORMED THAT YOU AND YOUR STAFF HAVE IMPLEMENTED PREVENTATIVE 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 COVD-19 BY PROCEEDING WITH THIS TREATMENT. I HEREBY ACKNOWLEDGE AND ASSUME THE RISK OF BECOMING INFECTED WITH COVID-19 THROUGH THIS ELECTIVE TREATMENT AND GIVE MY EXPRESS PERMISSION TO YOU AND THE STAFF AT YOUR OFFICES TO PROCEED WITH PROVIDING CARE.

PLEASE ANSWER ALL QUESTIONS:

HAVE YOU BEEN TESTED FOR COVID? YES / NO

_____ I CONFIRM I AM NOT EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS OF COVID-19 THAT ARE LISTED BELOW:

*FEVER *COUGH *SORE THROAT *SHORTNESS OF BREATH *SUDDEN LOSS OF TASTE OR SMELL *FATIGUE *CHILLS *NASAL OR SINUS CONGESTION *SUDDEN ONSET BODY ACHES

EXPOSURE:

ARE YOU AWARE OF HAVING BEEN EXPOSED TO SOMEONE WITH COVID-19 OR ANYONE WHO HAS BEEN EXPOSED TO SOMEONE WITH COVID-19? YES / NO

TRAVEL.

HAVE YOU DONE ANY AIR TRAVEL, DOMESTIC OR INTERNATIONAL, RECENTLY? YES / NO

HAVE YOU TRAVELED TO ANY PLACES WITH A HIGH INFECTION RATE, WHERE PEOPLE HAVE NOT BEEN ISOLATING (NO STAY AT HOME ORDER), OR BEEN IN ANY GROUPS OF PEOPLE WHERE SOCIAL DISTANCING WAS NOT OBSERVED? YES / NO

PRECAUTIONS

WHAT PRECAUTIONS HAVE YOU TAKEN TO LIMIT YOUR EXPOSURE TO THE VIRUS?

_____

_____

DO YOU SPEND TIME AROUND ANYONE CONSIDERED HIGH RISK, SUCH AS ELDERLY WITH CO-MORBIDITIES (MULTIPLE ILLNESSES OR DISEASES) OR IMMUNOCOMPROMISED FAMILY MEMBER YES / NO

ARE YOU WILLING TO WASH OR SANITIZE YOUR HANDS UPON ENTERING MY OFFICE AND POST-ACUPUNCTURE? YES / NO

ARE YOU WILLING TO WEAR A FACE MASK AT ALL TIMES IN MY OFFICE AND DURING THE TREATMENT? YES / NO

_____ 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 FURTHER CONDITIONS FOR WHICH I SEEK CARE FROM THIS OFFICE.

_____ PRINT NAME

_____ SIGNED NAME

_____ DATE

_____ WITNESS NAME

_____ WITNESS SIGNATURE

_____ DATE