COVID-19 Health Information & Informed Consent Waiver

Client Name: ____ Date: ___________________

This document contains important information about your decision to receive services considering the COVID-19 public health crisis. We reserve the right to decline services to anyone to protect the health and safety of all individuals. Please read and fill out this form carefully and let us know if you have any questions or concerns.

1. Yes ☐ No ☐ In the last 2 weeks have you had a fever of 100°F or above?
2. Yes ☐ No ☐ 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. Yes ☐ No ☐ In the last 2 weeks have you been in contact with anyone who has been diagnosed with COVID-19 or has coronavirus-type symptoms?
4. Yes ☐ No ☐ In the last two weeks have you traveled anywhere outside of the State?
   If yes where: ____
5. Yes ☐ No ☐ In the last 2 weeks have you had any loss of sense of taste or smell?
6. Yes ☐ No ☐ Can you exercise to get your heart rate and respiratory rate up without any problem?
7. Yes ☐ No ☐ Have you had a new onset of muscle aches and pain since the emergence of the virus?
8. Yes ☐ No ☐ Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin?

I have answered truthfully. 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 and have been instructed to follow health saving precautions like wearing a mask and cleanliness protocols.

______ 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 Massage work involves close physical proximity over an extended period in a closed space, there may be an elevated risk of virus/disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my written express permission to you, your staff or contractors at your offices or at my home or location of choice 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 OR AT MY HOME OR LOCATION OF CHOICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM YOU OR YOUR COMPANY, WAIVING ANY RESPONSIBILITY FOR MY DECISION TO SEEK TREATMENT, I AM THE SOLE RESPONSIBLE FOR MY DECISION.

Client Signature: ____ Date: _____________________

Therapist Signature: ____ Date: _____________________