COVID-19 Health Info & Informed Consent

Please initial and sign below

If you have any symptoms of viral illness such as fever, sore throat, fatigue and weakness, sneezing, cough etc. you must reschedule your appointment.
You will not be charged for a late cancellation.

Initials

I do not now, or have not recently had, any of the following symptoms:

Muscle aches	Dry Cough	Sore Throat	
Shortness of breath	Runny nose	Lost of taste or smell	_____

I have not been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or who has coronavirus symptoms. _____

Consent for 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. By signing below, I agree with the current or future recommendation to receive case as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office form my present condition and for any future conditions for which I seek care from this office.

Patient Signature: _____ Date: _____