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COVID-19 Informed Consent to Treat

In an ongoing effort to ensure patient safety, all patients must complete this COVID-19 Informed Consent to Treat. Should you have any questions or require further explanation of anything contained herein, please contact our office before signing and submitting this form. You may download and print a copy of this form for your records at http://www.wylandessentialtherapy.com/info/

COVID-19 Informed Consent to Treat

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. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involved 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 difficut.

To proceed with receiving care, I confirm and understand the following:

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

☐ I understand

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

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 understand

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 COVID-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. *

I agree to promptly notify my practitioner should I develop any cold or flu symptoms or suspected COVID-19 symptoms within 5 days of my treatment. * ☐ Yes ☐ No

I have been offered a copy of this consent form. (You may download a copy of this form at http://www.wylandessentialtherapy.com/info/) * ☐ 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 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.

PATIENT NAME * _____

_____

_____

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PATIENT or PARENT/GUARDIAN SIGNATURE : _____

Today's Date: _____