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Informed Consent for In-Person Services during COVID-19

I, the patient, understand that the novel COVID-19 has been declared a global pandemic by the World Health Organization. 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 informed choices. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

Decision to Meet Face-to-Face

My provider and I have agreed to meet in person for some or all future sessions. My provider may change precautions if additional local, state, or federal orders or guidelines are published. If this happens, we will talk about any necessary changes. Also, should a resurgence of the pandemic or if other health concerns arise, my provider may require us to meet via telehealth. Furthermore, if at any time I would feel safer utilizing telehealth, my provider will respect my decision, as long as it is feasible and clinically appropriate.

Risks of Opting for In-Person Serves [initial after each statement below]

- 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 that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to utilize telehealth platform. However, while I understand the potential risks associated with receiving face-to-face services during the COVID-19 pandemic, I agree to proceed with my desired treatment format. _____
- 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 the health care office. _____
- 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 & smell
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days traveled: 1) outside of the US countries affected by COVID-19 or 2) domestically within the US by commercial airline, bus, or train. _____

- I am informed that my provider has 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 my provider at her office to proceed with providing care. _____
- I understand, if I tested positive for COVID-19, my provider may be required to notify local health authorities that I have been in the office. If my provider needs to report this, my provider will provide the *minimum* information necessary for their data collection and will *not* go into any details about the reason(s) for our visits. _____
- 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 THE 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 THIS PROVIDER IN THIS OFFICE FOR MY PRESENT CONDITION FOR WHICH I SEEK CARE.

_____ (SEAL) _____

Signature of Patient Date

_____

Printed Name of Patient

_____

Signature of Witness/Provider