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COVID-19 Health Information & Informed Consent

Client Name: _____Date:_____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

COVID-19 Information

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐

2. 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)? Yes ☐ No ☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

4. Have you traveled anywhere outside of the state in the last two weeks? Yes ☐ No ☐

   Location: _____

5. Have you had a new loss of sense of taste or smell or eye irritation? Yes ☐ No ☐

6. Have you had a new onset of nausea, vomiting, diarrhea, abdominal pain, dizziness? Yes ☐ No ☐

The following questions are specific to a new aspect of COVID-19 involving blood coagulation.

7. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes ☐ No ☐

8. Have you had a new onset of muscle aches, pain, or blood clots in the lower limbs since the emergence of the virus? Yes ☐ No ☐

9. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes ☐ No ☐

Consent for Treatment

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 the virus carriers may not show symptoms and still be contagious. _____

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." It involves my understanding and agreement regarding recommended care and the benefits and risks of 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 this work involves close physical proximity over an extended time period 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 Gena L. Spencer, DACM, L.Ac. to proceed with providing care. _____

I understand that my name and contact information may be shared with the Sacramento County Health Department in the event that a client or practitioner at this site tests positive for COVID-19. Your contact details will only be shared if they are relevant based on suspected exposure date and appropriate follow-up by the health department. They can be reached at (916) 875-5881 if you have any questions.

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 FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Print Client Name: _____ Date: _____

Client Signature: _____ Date: _____