Informed Consent COVID-19

I _____ (patient name) understand that I am opting for an acupuncture treatment which requires close, personal contact. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Christie Savage of Harmony Acupuncture is closely monitoring this situation and has put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this treatment, I understand that I have the right to ask any questions about the safety procedures in place, and I may withdraw my consent at any time. I hereby acknowledge and assume the risk of becoming infected with COVID-19 during the office visit and I give my express permission for Christie Savage to proceed with the treatment.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test.

I understand that possible exposure to COVID-19 before/during/after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment.

I have been given the option to defer my treatment to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment.

_____

Patient Name (please print)

_____

Patient (or Guardian) Signature

_____

Date

If a Guardian has signed, please print your name:

_____