

## COVID-19 Health Information & Informed Consent

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 Health Questions (circle answers):

1. Within the last 14 days have you had close contact with anyone diagnosed with COVID-19 or has coronavirus type symptoms?
  - Yes
  - No
2. Have you had a fever within the last 24 hours of 100°F or above?
  - Yes
  - No
3. Have you received a COVID-19 vaccine?
  - Yes
  - No
  - Notes: \_\_\_\_\_

### Consent for Treatment

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

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

Full name (printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

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*For office use only*

Client's temperature reading: \_\_\_\_\_ PPE Variances: \_\_\_\_\_

To the best of my knowledge based on pre-screening questions and body temperature reading, I ascertain that this client appears to be in good physical health and can receive bodywork/energy work today. *Therapist Signature:* \_\_\_\_\_