



COVID-19 INFORMED CONSENT TO TREAT

The World Health Organization (WHO) has declared sARS-CoV-2, the virus that causes COVID-19, a global pandemic. COVID-19 is extremely contagious. It is thought to be spread mainly from person to person through respiratory droplets produced when an infected person coughs, sneezes, and breathes. It may also be spread through touching surfaces and objects upon which the droplets have been deposited, or by inhaling droplets through your nose or mouth. COVID-19 has a prolonged incubation period and persons infected with COVID-19 may not be symptomatic or show symptoms and may still be contagious.

- I understand that I am the decision maker for my health care, and that part of this office's role is to provide me with information to assist me in making informed decisions. I further understand that this process is often referred to "Informed Consent" and involves my understanding of the benefits and risks associated with the provision of health care and my agreement with recommended care.
- I understand that entering this office and receiving treatment at this office may create circumstances in which COVID-19 can be transmitted and contracted, such as the discharge of respiratory droplets or person-to-person contact.
- I understand that determining who is infected with COVID-19 is exceptionally difficult due to a prolonged incubation time and limitations in testing.
- 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, and while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree and wish to proceed with treatment at this time.
- I understand that I may have an elevated risk of contracting COVID-19 simply by entering a health care office due to the frequency of visitors and patients, the characteristics of procedures that are performed, and the contagious attributes of the virus that causes COVID-19.
- I confirm that I am not experiencing any of the following symptoms of COVID-19: sore throat, new loss of taste or smell, cough, runny nose, sneezing, fever, chills, shaking with chills, shortness of breath, difficulty breathing, headache, body aches or muscle pain, inflammation of testes, skin changes or rash, nausea, gastrointestinal upset, abdominal pain, vomiting, or diarrhea.
- I understand that travel increases my risk of contracting and transmitting the virus that causes COVID-19. I verify that in the past 14 days I have NOT traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train.
- I am informed that this office 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 entering this office or by proceeding with treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 and give my express permission to the health care providers at this office to proceed with providing treatment.

I have read or have had read to me, and have been offered a copy of this COVID-19 Informed Consent to Treat. I have had the opportunity to ask questions and I confirm that all of my questions have been answered to my satisfaction. The risks associated with entering this office and receiving treatment during the COVID-19 pandemic have been disclosed to me. I understand that there are a number of risks associated with my entering this office and receiving treatment at this office during the COVID-19 pandemic, including and without limitation: I could contract COVID-19 or other diseases which could result in a serious medical condition requiring medical treatment in a hospital and could possibly lead to death. I understand that it is not feasible to consider every possible complication of my care. I agree with my health care provider's current recommendation and any future recommendation to receive treatment as is deemed appropriate for me. I intend this consent to cover the entire course of my treatment from all health care providers in this office for my current condition(s) and for any future condition(s) for which I seek care from this office.

By signing below, I knowingly and freely consent to treatment, assume all risks, both known and unknown, relating to my entering this office or receiving treatment, and I hereby forever release, waive, relinquish, discharge, indemnify, and hold harmless Acupuncture and Integrative Medicine Associates of Nashua, PLLC along with their health care providers, officers, directors, managers, officials, trustees, agents, employees, or other representatives, and their successors and assigns, from any and all claims, demands, liabilities, rights, damages, expenses, and causes of action of whatever kind or nature, and other losses of any kind, whether known or unknown, foreseen or unforeseen, as a result of my entering this office or receiving treatment at this office, including but not limited to those related to personal injuries, health related conditions, death, disease or property losses, or any other loss or condition that may come from an infection with COVID-19.

PRINT PATIENT OR GUEST NAME: _____
PRINT NAME OF GUARDIAN (If applicable): _____
RELATIONSHIP TO PATIENT OR GUEST (self, guardian, etc.): _____
DATE: _____
SIGNATURE: _____