COVID-19 RISK INFORMED CONSENT TO TREAT

This document informs you, _____ of risks related to COVID-19 during any voluntary or elective procedures performed by Jennifer L. Anders, Lic. Ac., 1368 Beacon St. #110, Brookline, MA.

COVID-19 has been declared a worldwide pandemic by the World Health Organization, is highly infectious and spreads by person-to-person contact. This facility continues to closely monitor this situation and has implemented measures consistent with CDC, MA Department of Health and Human Services and public health orders aimed to reduce the spread of COVID-19. However, given the nature of the virus, there remains an inherent risk of becoming infected with COVID-19 by virtue of proceeding with your voluntary or elective treatment/procedure. As a patient of Jennifer L. Anders, Lic. Ac., your health and safety is our priority. Please review the following in clinic treatment provisions and initial and sign as follows:

(Initial) _____I have not tested positive for COVID-19 within the last 30 days.
(Initial)_____ I have not exhibited any symptoms of COVID-19 including a combination of cough, body aches, fatigue, and chest tightness within the last 14 days.
(Initial) _____I consent at all times to wearing a mask, hand washing and other procedures as instructed by staff during my office visit.
(Initial)_____ I agree to immediately inform Jennifer L. Anders, Lic Ac., if I test positive for COVID-19 or begin to exhibit symptoms of the virus within 14 days of my office visit.
(Initial)_____ I understand that while Jennifer L. Anders, Lic. Ac. has implemented measures to limit the spread of COVID-19 there remains an inherent risk of becoming infected with COVID-19 by virtue of proceeding with my office visit for this voluntary or elective treatment/procedure.
(Initial)_____ I have been given the option to defer my treatment/procedure to a later date or to participate in tele-health measures and am declining those options.

I KNOWINGLY AND WILLINGLY CONSENT TO TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM THAT ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient Signature_____

Printed Patient Name_____

Practitioner Signature_____

Date_____