BETTINA SCHULER
M.S., L.AC.

COVID -19 PANDEMIC TREATMENT CONSENT FORM

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization. I further understand the virus is highly contagious and may be contracted from various sources. I understand it has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. Given the current limitations of COVID-19 virus testing, I understand determining who is infected is exceptionally difficult. I understand there is inherent risk to become infected with the virus by virtue of proceeding with any healthcare treatment. _____ (Initial)

I understand that I am opting for an elective treatment that may or may not be medically necessary, and that I have the option to defer my treatment to a later date. While I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____ (Initial)

I understand my treatment may create circumstances, such as discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____ (Initial)

I understand that travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT traveled in the past 14 days: 1) Outside the United States to countries infected by COVID-19 virus; or 2) Domestically within the US by commercial airline, bus, or train. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed here: fever, shortness of breath, loss of sense of taste or smell, dry cough, runny nose, sore throat. _____ (Initial)

I agree that if I begin to feel ill and test positive for COVID-19 within 14 days of my treatments, I will contact my healthcare provider. This will help the healthcare provider's office take steps to keep other people from getting exposed or infected. Similarly, my healthcare provider will inform me if she reports becoming ill and testing positive for COVID-19 within 14 days of my treatment. _____ (Initial)

I am informed that this office has implemented preventive measure intended to reduce the spread of COVID-19 such as: limiting appointments, patient screening procedures, social distancing, using Personal Protective Equipment (PPE), enhanced disinfection procedures including disinfecting between clients, and following guidelines set forth by the CDC and local NY State health department and governmental mandates. However, given the nature of the virus, I understand that there may be inherent risk of becoming infected by proceeding with this treatment. _____ (Initial)

I KNOWINGLY AND WILLINGLY CONSENT TO TREATMENT BY BETTINA SCHULER L.AC. WITH 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 SATISFATION, AND HAVE BEEN OFFERED A COPY OF THIS CONSENT FORM.
I HAVE READ, OR HAVE READ TO ME, THE ABOVE COVID-19 INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Name or Patient Representative:_____

Signature of Patient or Patient Representative:_____

Date of Consent: _____