CENTER POINT

ACUPUNCTURE WITH ELIZABETH

Patient Advisory, Acknowledgment, and Informed Consent

Receiving Acupuncture Treatment During the SARS-COV-2 Pandemic

You have presented today for acupuncture treatment, which is an elective procedure. Be assured that we are following federal, state and industry regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in this office, including SARS-CoV-19/COVID-19.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge. COVID-19 is extremely contagious and may be contracted from various sources. COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. Despite our careful attention to disinfection and the use of personal barriers there is still a chance that you could be exposed to an illness in our office.

To reduce the risk of spreading SARS-COV-2, we have asked you several screening questions on page 2 below. For the safety of our staff, other patients, and yourself, please be truthful in your answers.

Although exposure is unlikely, do you accept the risk and consent to treatment? ______Yes ______No

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 PATIENT ADVISORY, ACKNOWLEDGEMENT, AND INFORMED CONSENT. 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 FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

____ ________________

Patient/Responsible Party Date

Please initial "Yes" or "No" in response to the following questions

Do you have a fever? ______Yes ______No

Do you have any new shortness of breath? ______Yes ______No

Do you have a new dry cough? ______Yes ______No

Do you have any other flu-like symptoms? ______Yes ______No

Have you experienced recent loss of taste or smell? ______Yes ______No

Contact with any confirmed COVID-19 positive people? ______Yes ______No

Within the last 14 days:

Have you travelled to any foreign country? ______Yes ______No

Have you travelled within the US? ______Yes ______No

If so, where?____

____ ____________________

Patient/Responsible Party Date