Ultimate
Health Clinic

## COVID-19 pre-screening

**Name:** _____ **Date:** _____

By attending my appointment...

I agree that I am not currently experiencing any of these symptoms:

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Sore throat
- New loss of taste or smell

Please note: Other less common symptoms have been reported, including gastrointestinal symptoms like nausea, vomiting, or diarrhea.

I agree that I have not:

- Tested positive for COVID-19
- Knowingly been exposed to someone with COVID-19
- Recently traveled to an area with a high infection rate
- Been in an area where social distancing was not properly observed
- Been to a nursing home

If you have experienced any of the above, please reschedule your appointment at least 14 days from now.

I agree that I have not experienced any of the above and the information I have provided on this form is truthful an accurate.

**Signature:** _____ **Date:** _____

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# COVID-19 RISK INFORMED CONSENT

- I _____understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization.
- I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, public health agencies recommend social distancing.
- I recognize that Ultimate Health Clinic is closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19.
  However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this treatment.
- I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test.
- I understand that possible exposure to COVID-19 before/during/after my treatment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment and possible need for intubation/ventilator support.
- I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment itself. I have been given the option to defer my treatment to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE TREATMENT.

Client's name: _____ Date: _____

Client's signature: _____ Date: _____