CONSENT FOR CHIROPRACTIC TREATEMENT DURING THE COVID-19 PANDEMIC

## I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, knowingly and willingly consent for myself or for a minor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, under my care, to receive elective Chiropractic or emergency Chiropractic treatment from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [insert practitioner’s name] during the COVID-19 pandemic.

## I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious.

## Chiropractic procedures/treatment take place with the patient in very close proximity to the practitioner. This potentially exposes the patient and the practitioner to the COVID-19 virus.

## I understand that due to the frequency of visits of other Chiropractic patients, the characteristics of the virus, and the characteristics of Chiropractic practice, that I have an elevated risk of contracting the virus simply by being in a Chiropractic office. \_\_\_\_\_\_\_ (Initial)

## I acknowledge that it is still recommended where possible and practical that consultations be held via videoconferencing software or through Telehealth technologies.

## I confirm I am seeking treatment for a condition that cannot be done effectively or practically via Telehealth technologies.

## I confirm that I am not presenting ANY of the following symptoms of COVID-19 listed below:

### Fever

### Shortness of Breath

### Dry Cough

### Runny Nose

### Sore Throat

## High risk patients relating to the severity of COVID-19 are persons over the age of 60 and persons who have pre-existing medical conditions such as: asthma, chronic lung conditions, hypertension, autoimmune diseases, organ transplants, cancer, Immunocompromised, Obesity (BMI over 40) and Liver or kidney conditions. I confirm that I do not fall into any of these high risk categories.

## In person consultations and treatment will only be done for high risk patients if absolutely necessary and in emergencies.

## I am aware of the risks involved with the spread of COVID-19 and the risks it may hold to my health and the health of others I come in contact with. I accept those risks and hereby indemnify and hold the practitioner and his/her staff blameless should I contract the disease at the offices of the practitioner or from the practitioner or his/her staff members.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature DATE

(Parent/Guardian)

PRACTICAL GUIDELINES TO THE CONSULTATION:

## I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and understand the practical guidelines as set out hereunder and confirm that I will comply thereto and prepare accordingly.

### I will sign all consent forms at home with my own pen and bring the forms to the practitioner’s practice, failing which I will not be treated. I may also sign same electronically and email same to the practitioner.

### Patients will be phoned and screened the day before consultations, and requested to take appropriate action if they are presenting with any risk symptoms or history.

### Patients will be stopped from entering the practice if the patient hasn't complied with proper control measures.

### Patients will not be allowed in the waiting room and will be requested to wait in their cars until called by the practitioner or a staff member to enter the practice.

### All patients will be sprayed with hand sanitiser upon entry.

### All patients must wear a face mask alternatively a face mask will be provided to the patient.

### On arrival, patients will again be screened for risk factors including the taking of a temperature.

### Between consultations, the necessary hygiene/cleaning protocols will be done by the practitioner and/or their staff compliment and this may cause a delay and prolong waiting periods.

### Patients are requested to avoid touching anything inside the practice.

### Patients are requested to remove any jewellery and leave same at home as it can be carriers of infections droplets.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature DATE

(Parent/Guardian)