

CONSENT FOR CHIROPRACTIC TREATMENT DURING THE COVID-19 PANDEMIC

1. 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.
2. 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.
3. 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.
4. 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)
5. I acknowledge that it is still recommended where possible and practical that consultations be held via videoconferencing software or through Telehealth technologies.
6. I confirm I am seeking treatment for a condition that cannot be done effectively or practically via Telehealth technologies.
7. I confirm that I am not presenting ANY of the following symptoms of COVID-19 listed below:
 - 7.1. Fever
 - 7.2. Shortness of Breath
 - 7.3. Dry Cough
 - 7.4. Runny Nose
 - 7.5. Sore Throat
8. 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.
9. In person consultations and treatment will only be done for high risk patients if absolutely necessary and in emergencies.
10. 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
(Parent/Guardian)

DATE

PRACTICAL GUIDELINES TO THE CONSULTATION:

1. I, _____ have read and understand the practical guidelines as set out hereunder and confirm that I will comply thereto and prepare accordingly.
 - 1.1. 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.
 - 1.2. 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.
 - 1.3. Patients will be stopped from entering the practice if the patient hasn't complied with proper control measures.
 - 1.4. 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.
 - 1.5. All patients will be sprayed with hand sanitiser upon entry.
 - 1.6. All patients must wear a face mask alternatively a face mask will be provided to the patient.
 - 1.7. On arrival, patients will again be screened for risk factors including the taking of a temperature.
 - 1.8. 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.
 - 1.9. Patients are requested to avoid touching anything inside the practice.
 - 1.10. Patients are requested to remove any jewellery and leave same at home as it can be carriers of infections droplets.

Patient's Signature
(Parent/Guardian)

DATE