COVID-19 Pandemic Treatment Consent Form for Kunlun Mountain Acupuncture

I, ____, knowingly and willingly consent to have acupuncture and/or massage treatment at Kunlun Mountain Acupuncture completed during the COVID-19 pandemic. I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I understand the COVID-19 virus can have an incubation period during which carriers of the virus may not show symptoms and still be highly contagious. I understand that current data shows that even fully vaccinated individuals may not show symptoms while still carrying viral loads significant enough to transmit the illness. It is impossible to determine who is contagious and who is not. ________ (Initial)

I understand that while my providers follow recommended CDC and CMS guidelines for universal precautions in medical facilities during the COVID-19 pandemic, it is impossible to guarantee the absence of exposure and the safest way to decrease exposure is to stay at home. ________ (Initial)

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. I confirm I am seeking treatment for a condition that meets these criteria. _____ (Initial)

I understand that the CDC recommends social distancing of at least 6 feet and this is not possible with acupuncture and massage visits. I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. __________ (Initial)

In accordance with CDC guidelines and requirements of the Maryland Department of Health, I have prescreened myself prior to arriving for treatment. To my knowledge I have not been in contact with a COVID-19 positive or presumed positive person within the last 14 days, and I confirm that I am not presenting any of the following symptoms of COVID-19:

Fever, Shortness of Breath, Loss of Taste or Smell, Dry Cough, Runny Nose, Sore Throat ___________ (Initial)

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 COVID-19 RISK INFORMED CONSENT TO TREAT. 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.

Signature____ Date____________________
(Legal Guardian if Patient is Under 18 Years of Age)

Witness____ Date___________________