

OFA CLIENT PROTOCOLS FOR RECEIVING CARE--MANDATORY EACH VISIT

---EVERYONE SHALL WEAR A 2+ LAYER CLOTH or SURGICAL MASK OVER NOSE & MOUTH

AT ALL TIMES INSIDE OUR CLINIC.

---VIRTUAL APPOINTMENT CHECK-IN PROCESS--Wait in your car till we connect with you.

*WHEN YOU ARRIVE, USE LINK BELOW TO CHECK INTO OUR WAITING ROOM

<https://www.olympiafamilyacupuncture.com/pre-treatment-check-in>

---PASS YOUR COVID RISK ASSESSMENT WITH FLYING COLORS

---AGREE TO STAY HOME IF

*YOU ARE IN A HIGH RISK GROUP

(if you are over 65, obese, diabetic, heart/lung disease, autoimmune compromised, hypertensive, clotting disorders etc)

*YOU ARE EXPERIENCING ANY RESPIRATORY SYMPTOMS AT ALL

Fever Shortness of Breath Dry Cough Runny Nose Sore Throat Loss of Taste or Smell

*YOU HAVE HAD A FEVER IN THE PAST 2 WEEKS OVER 100.4

*YOU HAVE HAD CONTACT WITH SOMEONE WHO IS ILL WHO HAS NOT A NEGATIVE COVID 19 TEST

*YOU ARE NOT USING PPE AND DISTANCING AT ALL APPROPRIATE TIMES.

*YOU HAVE TRAVELED OUTSIDE OF THE COUNTRY/HAVE USED PUBLIC TRANSPORT

---CONSENT TO RECEIVE CARE AFTER READING THE BELOW INFORMED CONSENT.

COVID 19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

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. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

Initial To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)

Below

- 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.

- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.

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- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office.

- I understand that I should not come in if I am experiencing any of the following symptoms of COVID-19

including:

Fever Shortness of Breath Dry Cough Runny Nose Sore Throat Loss of Taste or Smell

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train.

- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.

- I have been offered a copy of this consent form. 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.

CLIENT NAME _____

CLIENT (OR GUARDIAN) SIGNATURE _____

DATE _____