COVID-19 Pandemic Chiropractic Therapy Consent Form

Patient Name: ____ Date: _____________________________

Essential Care Provided:

Chiropractic manipulation and necessary physiotherapies
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Chiropractic Team Members Involved in Care:

Kerr County Chiropractic. Dr. Kelsey Jones DC, Jennifer Smith
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I, _____________________ [Patient] understand, that as with any healthcare procedure, there may be certain side effects which may arise during chiropractic manipulation and therapy.

Everyone is aware of the COVID-19 Pandemic and current recommendations and restrictions instituted by federal, state and local governments. Detailed information on the COVID-19 virus can be obtained from the Centers for Disease Control and/or your local and state government entities.

This chiropractic visit is for the provision of essential care for pain that affects and inhibits my activities of daily living. This chiropractic provider has engaged in sanitation and safety protocols to slow and/or prevent the spread of COVID-19. I understand that due to the nature of chiropractic therapy, the CDC's recommended distancing of 6ft cannot be maintained during my treatment. Close contact must occur for the performance of examination and treatment by my chiropractor.

I understand that COVID-19 has a long incubation period during which the carriers of the virus may not show symptoms and still be contagious. It is impossible to determine who has it and who does not, given the current limitations in virus testing. I understand that this means I could be carrying the COVID-19 virus or someone I come into contact with may be a carrier without their knowledge.

I understand that there are certain risks and increased potential for infection by leaving my home to undergo necessary and essential chiropractic therapy during the COVID-19 Pandemic, regardless of sanitation and safety procedures instituted. By signing below, I acknowledge that I consent to receive chiropractic evaluation and treatment during the COVID-19 pandemic.

I agree that I have not exhibited any symptoms of COVID-19, including but not limited to: fever, shortness of breath, dry cough, or sore throat. __________________ (Initial).

I confirm that I have not travelled internationally in the last 14 days or travelled domestically within the last 14 days by plane, train, or bus. __________________ (Initial).

I have not been diagnosed with COVID-19 (in the past 5 days). __________________ (Initial).

I have not been in close contact [less than 6ft.] with another person who has been diagnosed or is awaiting results of testing for COVID-19. __________________ (Initial).

This chiropractic provider reserves the right to contact their local and state health department authorities to report any Patient suspected of having COVID-19.

___________________________________ ___________________________________

Patient Signature/Authorized Representative: Date: