COVID-19 INFORMED CONSENT TO TREATMENT

I understand that I am opting for a healthcare treatment and 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 believed to be spread by person-to-person contact; and as a result, Provincial Health Agencies including the British Columbia Centre for Disease Control, Worksafe BC and the regulating colleges for Massage Therapy and Acupuncture have provided requirements and guidelines that Health Care providers must adhere to. I understand that the practitioners at the Goodlife Wellness Centre are closely monitoring this situation and have put in place reasonable preventable measures aimed at reducing the spread of COVID-19. However, given the nature of this virus with an incubation period of up to 14 days in which carriers of the virus may not show any symptoms but may still be contagious, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with any health care treatment.

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

- I understand my treatment may create circumstances, such as the discharge of reparatory droplets or person-to-person contact, in which COVID-19 can be transmitted.
  Initial _____

- 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 include receiving care from another type of provider, or postponing care all together at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with desired treatment at this time.
  Initial _____

- 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.
  Initial _____

- I am informed that the practitioners of the Goodlife Wellness Centre have implemented preventive measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand that there may 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 though this elective treatment and give my permission to you to proceed with providing care.
  Initial _____

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that in the past 14 days I have not travelled outside of Canada.
  Initial _____

- I understand that I am the decision maker for my health care. Part of this offices 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 provisions 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 _____

- I understand that if it is believed that there has been of COVID-19 exposure in the clinic that my practitioner is required to share my name and contact information with the BCCDC.
  Initial _____

- A copy of this consent has been offered to me.
  Initial _____

I have read, or have had read to me, the above COVID-19 Informed Consent to Treatment. I appreciate that it is not possible to consider every possible complication to receiving care. I have also had an opportunity to ask questions about its consent, and by signing below, I agree with the current or future recommendations to received care as is deemed appropriate for my circumstances. I intend the consent cover the entire disclosure of my care from my practitioner for the present condition and for any future condition(s) for which I may seek.

By signing below I knowingly and willing consent to treatment with the full understanding and knowledge and assume the risks of becoming infected with COVID-19 through this healthcare office and wave all legal action should I become infected with COVID-19. I confirm all of my questions were answered to my satisfaction.

Patient Name:_____ Date: _____

Patient Signature: _____

Patient/ Guardian Name: _____ Date: _____

Patient/ Guardian Signature:_____

Practitioner Name:_____ Date:_____

Practitioner Signature:_____