

JUNCTION NATUROPATHIC MEDICINE (JNM): **COVID-19 INFORMED CONSENT for IN-OFFICE TREATMENT**

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 JNM’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.

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

Initial 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 in-office visit that may not be urgent or medically necessary, and that I have the option to defer my in-office visit to a later date or to a TeleMedicine visit. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired in-office visit at this time. _____
- I understand due to the frequency of appointment with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

*Fever	*Dry Cough	*Sore Throat
*Shortness of Breath	*Runny Nose	*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: 1) travelled outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the US by commercial airline, bus, train 3) been in contact with a person suspected of COVID-19 _____
- I am informed that JNM has implemented preventive measures intended to reduce the spread of COVID-19. Given the nature of the virus, I understand there may an inherent risk of becoming infected with COVID-19 by proceeding with an in-office visit. I acknowledge and assume the risk of becoming infected with COVID-19 through this in-office visit and give my permission to JNM to proceed with providing in-office care. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this in-office visit and give my permission to JNM to proceed with providing care. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE IN-OFFICE VISIT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING IN-OFFICE CARE DURING THE COVID-19 PANDEMIC.

I HAVE READ THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I UNDERSTAND 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 DR. JEANA KIMBALL AT JNM AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient
Signature: _____

Guardian
Signature: _____

Name: _____

Name: _____

Date: _____

Date: _____