

The Center for Holistic Healing - COVID-19 In Person Reiki or Ayurvedic Session Consent

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.

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

1. 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 Statement _____

2. I understand that I am opting to participate in sessions in the office with my provider. I understand there are alternatives to receiving this care, which could include receiving care from this provider online instead of in person. However, while I understand the potential risks associated with receiving in person treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment of in person sessions at this time.

Initial Statement _____

3. 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 Statement _____

4. I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

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

Initial Statement _____

5. If I test positive for covid-19, or am a presumptive positive, before entering The Center for Holistic Healing, I will have met all 3 of the following criteria:
 - a. No fever for 72 hours
 - b. Other symptoms have vastly improved
 - c. At least 14 days since symptom onset

Initial Statement _____

6. 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 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.

Initial Statement _____

7. 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 in person sessions and give my express permission to you and the staff at your offices to proceed with providing care.

Initial Statement _____

8. I am aware of the requirement to wear a face mask while at The Center for Holistic Healing and am willing and able to comply with this requirement. If needed, a paper mask can be provided to me at the time of my session.

Initial Statement _____

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

Initial Statement _____

10. I agree to the following:

If the staff of The Center for Holistic Healing becomes aware that through your contact here you have had an exposure to COVID-19, or if you have exposed others to COVID-19, the following applies regarding HIPPA:

HIPAA - Disclosures for Public Health Activities [45 CFR 164.512(b)]

The HIPAA Privacy Rule allows covered entities to disclose protected health information (PHI) to public health authorities when required by federal, tribal, state, or local laws [45 CFR 164.512(a)]. The Privacy Rule expressly permits PHI to be shared for specified public health purposes. The Privacy Rule permits covered entities to disclose PHI, without prior client consent, to public health authorities or other entities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This includes the reporting of disease or injury and conducting public health surveillance. [45 CFR 164.512(b)].

For disclosures not required by law, covered entities may still disclose, without client consent, to a public health authority authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability, the minimum necessary information to accomplish the intended public health purpose of the disclosure [45 CFR 164.512 (b)].

To protect the health of the public, public health authorities might need to obtain information related to the individuals affected by a disease. In certain cases, they might need to contact those affected to allow for actions to prevent further illness. [45 CFR 164.512(b)(1)(i)].

If we are required to disclose your information, you are aware that we will disclose the minimum amount of information necessary, to include your name, contact information, and the date of exposure.

Initial Statement _____

I KNOWINGLY AND WILLINGLY CONSENT TO IN PERSON SESSIONS AND TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING IN PERSON 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 Signature: _____

Printed Client Name: _____

Date: _____

Parent/Guardian Signature: _____

Printed Parent/Guardian Name: _____

Date: _____