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. 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 in-office care from Dr. Laura Kostrzewski, ND, I understand that I must agree to the following terms. **Please initial below to indicate your understanding and agreement:**

I understand my in-office care 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, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my in-person treatment at this time.	
I understand due to the frequency of appointments with patients at a health care center and the attributes of the virus, I may have an elevated risk of contracting COV1D-19 simply by being in a health care office.	
I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed here: Fever, Dry Cough, Sore Throat, Shortness of Breath, Runny Nose, or 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 traveled in the past 14 days: (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 Dr. Kostrzewski has 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 in-office care. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and care and give my express permission to Dr. Kostrzewski to proceed with providing me in-office care.	
I understand that a copy of this form will be placed in my medical record.	

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING IN-OFFICE 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 DR. LAURA KOSTRZEWSKI, ND FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM DR. KOSTRZEWSKI.

Patient Signature: ___________________________ Name: ___________________________ Date: ________________

Parent/Guardian
Signature: _________________________________ Name: ___________________________ Date: ________________