Kansas City Therapy

IN OFFICE INFORMED CONSENT DURING THE COVID-19 PANDEMIC

Client's
Initials

_____ I understand I have an option of using Telehealth, and I am choosing to come into the office instead.

_____ I agree I do not currently have a cough or a fever or difficulty breathing, all of which are symptoms of COVID-19. I agree that in the future I will not come in for an appointment if I have any of these symptoms.

_____ I agree to stay at least 6 feet away from my clinician while I am at the office.

_____ I understand it is my responsibility to follow all local, state, and federal guidelines to help protect myself and others from getting the disease and/or spreading the disease.

_____ I agree to waive and release my healthcare provider and his or her practice from any claims I may have if I do contract the COVID-19 virus.

_____ _____
Print Client Name Date of Birth

_____ _____
Client or Legal Representative Signature Date

_____
Clinician Signature