I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, knowingly and willingly consent to have treatment completed during the COVID-19 pandemic at Osteopathy Chicago, Ltd.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious.  It is impossible to determine who has it and who does not given the current limits in virus testing. \_\_\_\_\_\_ (**initials**)

I understand that due to the frequency of visits of other patients, the characteristics of the virus, and the characteristics of potential procedures, that I have an elevated risk of contracting the virus simply by being in a medical office.  \_\_\_\_\_\_ (**initials**)

I have been made aware of the CDC guidelines that under the current pandemic all non-urgent care is better handled by telemedicine visits.  \_\_\_\_\_\_\_ (**initials)**

I confirm that I am **NOT** presenting with any of the following symptoms of COVID-19 listed below.  \_\_\_\_\_\_\_(**initials**)

* FEVER (greater than 100.4 °F)
* SHORTNESS OF BREATH
* DRY COUGH
* RUNNY NOSE
* SORE THROAT
* SNEEZING, WATERY EYES, OR SINUS PAIN OR PRESSURE UNRELATED TO SEASONAL ALLERGIES
* HEADACHES, FATIGUE, OR WEAKNESS
* LOSS OF SENSE OF TASTE OR SMELL

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus.  I also understand that the CDC recommends social distancing of at least 6 feet and that this will NOT be possible with my treatment today. \_\_\_\_\_\_\_\_(**initials**)

I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19.\_\_\_\_\_\_(**initials**)

I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. \_\_\_\_\_\_\_(**initials**)

I verify that I have not been in contact with any confirmed COVID-19 positive patients or other sources who have been ill, tested positive or pending results for COVID-19 within the last 14 days.\_\_\_\_\_\_\_(**initials**)

Please read the entire consent before you sign your form.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Printed Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date\_\_\_\_\_\_ Temperature** \_\_\_\_

**Electronic Signatures**

Typing your name exactly as it appears on your birth certificate signifies you are completing this form using an electronic signature. By signing electronically you are certifying that you have read and understand the consent form and agree to electronically sign.