PELVIC & ORTHOPEDIC
PHYSICAL THERAPY SPECIALISTS

PATIENT CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

COVID-19 ADDENDUM

1. **Acknowledgment**: I acknowledge the current circumstances regarding the COVID-19 pandemic and desire to proceed with the care and treatment prescribed by my medical practitioner and/or considered necessary or advisable by my medical practitioner. I acknowledge that very little is known about the acute and long-term effects on COVID-19 on individuals; that over the course of time, there is a high risk I will at some point be exposed to COVID-19; that there is no way to predict my body's response to exposure and that this could range anywhere from no symptoms to severe illness, possibly including death. I will not visit the clinic if I am experiencing any symptoms of COVID-19 and I acknowledge that you may deny me entry into the clinic based upon my condition or other health factors. I acknowledge that it is a time of rapidly changing information and recommendations. I have been advised to review the most recent recommendations for the most up to date information. Recommended websites include: The United States Center for Disease Control (CDC), The World Health Organization (WHO).

2. **Multiple Treatments**: I am aware that my treatment may require multiple clinic visits. Although efforts will be made to hopefully lower my risk of COVID-19 exposure during these visits, there is no way to guarantee prevention of exposure. Current evidence supports transmission of the virus before and without any symptoms of infection. Undergoing treatments will inadvertently pose opportunity for exposure to COVID-19.

3. **Cancellations**: I acknowledge that during this time of rapidly changing information and evolving recommendations/restrictions, my treatment may be cancelled by you at any time.

4. **Indemnity**: I knowingly and freely choose to enter into treatments and release and hold harmless Pelvic & Orthopedic Physical Therapy Specialists, and its affiliates, partners, physicians, nurses, clinicians, support staff, and other members, formal or informal, of the team from all fault, coercion, negligence, liabilities, actions or inactions, which may cause harm whether minor or serious to me.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Legally Responsible Person Date

_____ _____
Printed Name of above (if not the Patient) Date