ESTI KRüGER BIOKINETICIST
Pr Number: 0251631
HPCSA: BK 0009458
+27 60 9833387
esti@ekbiokineticist.co.za

COVID-19 Treatment Consent Form

I, (the patient), _____ consent to receive treatment from Esti Krüger Biokineticist during the COVID-19 outbreak.

I have agreed to meet in person for some or all future sessions. If the practice has health risk concerns about future in person consultations the practice may also resolve to other consultation methods such as telehealth.

I understand that by going to the practice, I am assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if I travel by public transportation, taxi, or ridesharing service.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmits.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contacts. I understand that close contact can occur from being within approximately 1.5 m of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to the unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that the symptoms listed below are representative of COVID-19:

Fever or Chills	Loss of taste or smell
Headache	Sore throat
Dry cough	Muscle or body aches
Tiredness / Fatigue	Diarrhea
Shortness of Breath or difficulty breathing	Nausea or vomiting
Conjunctivitis	Skin rash or discolouration on fingers or toes
Congestion or runny nose	

I confirm that I do not display or currently have any of the symptoms that are representative of COVID 19, which are outlined above: _____(Initial)

I understand that if I do suspect that I have been in contact with anybody who displayed COVID-19 symptoms, or if I have any symptoms, I should stay home for 10 days to practice social distancing and monitor my health.

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID- 19 in the past 14 days. Further should I later become aware that I was in contact with Covid-19 positive individual prior to any appointment at the practice I will inform the practice of such contact. _____ (Initial)

I undertake to adhere to the practice's safety precautions including but not limited to: social distancing, wearing a face mask, sanitizing and washing of hands, temperature measurement etc. I hereby specifically indemnify the practice (in the event that I contract COVID-19 or any other disease from the practice) of any form of prosecution and/or any claims of any nature.

Patient/Guardian Name:_____ Patient/Guardian Signature:_____

Date: _____