NORTH WALSHAM CHIROPRACTIC CLINIC COVID-19 CONSENT FORM

We've made a number of changes to the clinic to help with social distancing, ensure strict hygiene standards, and protect one another using Personal Protective Equipment.

Despite these precautions, there is an inherent risk of human-to-human transmission of the Coronavirus (COVID-19).

How does Coronavirus Spread?

This virus is thought to be easily spread from close person to person contact (within 2 meters) or through respiratory droplets produced when an infected person coughs or sneezes. This can occur with or without the person showing any symptoms.

We have requested any symptomatic patients to stay away from the clinic at this time.

We are doing all that we reasonably can to minimise your risk of exposure to Coronavirus. However, we cannot guarantee that there is no risk to you as a result of attending the clinic and/or receiving treatment.

If you are in the "at risk" group

If you, or someone in your household, are:

- Over 70
- Have any underlying health conditions that increase vulnerability from COVID-19
- Have a weakened immune system
- Pregnant

You must weigh up the potential risks against the benefits of receiving treatment. Please see our website or posters in the clinic for further information.

Consent to receive care

- I confirm that to the best of my knowledge, I have not experienced any COVID-19 symptoms in the last 7 days, and I have not been in contact with anyone who has in the last 14 days. I also agree to ensure this is the case before any future visits to the clinic.
- I understand that the risk of transmission of Coronavirus (COVID-19) cannot be completely mitigated despite all the precautions in place.
- I understand that North Walsham Chiropractic Clinic cannot accept responsibility for the transmission of Coronavirus (COVID-19) should I become unwell.
- I understand that my name and contact details may be given to the NHS test and trace service if required.
- I have had the chance to ask all the questions I wish to at this time.

I have read and understood the above statements and give my full informed consent to receiving treatment.

Patients Name: ____

Signed: ____

(If you are under 16 years of age, this consent should be signed by a parent or guardian)

Date: ____