Supplemental
Informed Consent

TEAM Services in the Era of COVID-19

Thank you for your continued trust in our services. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our offices and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you can be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our offices, due to the nature of the services we provide, it is not always possible to maintain social distancing between the clients and staff at all times.

Although exposure is unlikely, do you accept the risk and consent to services?

☐ YES ☐ NO

Patient Name _____

Parent/Guardian Name *(if applicable)* _____ Relation_____

Patient/Parent/Guardian Signature _____ Date_____

TEAM Wellness at Work

COVID-19 Pandemic – Client Disclosures

This client disclosure form seeks information from you that we must consider before providing services in the circumstance of the COVID-19 virus. Please complete and return this form in the 24-hour period of time prior to your appointment.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk of contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling your appointment after discussing such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	In the last 14 days:	Yes	No
1.	Do you have a fever, chills or above normal temperature?	☐	☐
2.	Have you experienced shortness of breath or had trouble breathing?	☐	☐
3.	Do you have a dry cough?	☐	☐
4.	Do you have congestion and/or runny nose?	☐	☐
5.	Have you recently lost or had a reduction in your sense of smell?	☐	☐
6.	Do you have a sore throat?	☐	☐
7.	Do you have nausea, vomiting or diarrhea?	☐	☐
8.	Do you have a headache?	☐	☐
9.	Do you have muscle or body aches or feel fatigue?	☐	☐
10.	Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
11.	Have you tested positive for COVID-19?	☐	☐
12.	Have you been tested for COVID-19 and are awaiting results?	☐	☐
13.	Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
14.	Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

It is our current practice to require that individuals seeking in person services wear a mask in office common areas. Masks are available at no cost if needed. Additionally, please know TEAM staff may ask to take your temperature with a no touch, infrared thermometer as you enter the office space.

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to TEAM any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature _____ **Date** _____