Thrive Acupressure

New" Covid-19 Informed Consent Waiver

Informed Consent: In the current environment of Covi-19 risk, informed consent requires that the patient be informed and understands that:

1) To the best of my knowledge I qualify to be treated according to the Protocols of Thrive Acupressure. **Yes or No (Circle One)**

2) Any hands on treatment involves some risk of Covid-19 transmission. The Therapist is following protocols to help reduce or mitigate risk where possible, but that risk cannot be reduced to zero. **Do you understand? Yes or No (Circle One)**

3) The client consents to a treatment from Gigi Huscroft at Thrive Acupressure despite some risk. **Yes or No (Circle one)**

4) How long of a treatment would you like? 1------1.5 (Circle One)

5) What Services would you like today**? Shiatsu Massage & 5-Element Acupressure; Ashiatsu; Touch For Health, SIPS, Body Talk, EFT-Tapping; Wellness with SOTA Instruments or Any. Circle all** of the treatments you are interested in please?

6) **Have you received the Covid-19 shot? Yes or No**

When?_____Which one?_____

_____Sign _____Date

_____Print Name_____Phone#

“New" Covid-19 Screening Questionnaire

1. Do you have a fever? **Yes or No**

2. Do you have any of the following signs or symptoms?

____New onset of cough or worsening Chronic cough

____Sore Throat or difficulty swallowing

____Shortness of Breath, or difficulty breathing

____New loss or decrease in sense of taste or smell

____Sneezing (Not allergy related)

____Hoarse voice

____Chills

____Unexplained fatigue or malaise, Can’t walk up stairs

____Nausea/vomiting, diarrhea, abdominal pain

____"No"-None of the above

3. Have you traveled or have had close contact with anyone who has **traveled outside BC or Canada** in the past 14 days? **Yes or No.**

4. Have you had **close contact** with anyone with confirmed or probable/suspected case of COVID-19 or the flu? **Yes or No**

5. Have your visited a **long term care facility** in the past 14 days? **Yes or No**

6. Have you visited or worked in a **hospital** in the past 14 days? **Yes or No**

7. Are you involved in healthcare and seeing out of town clients? **Yes or No**

If you have answered "Yes" to any of the above screening questions you may need to consider rescheduling your appointment.

In Office "New" Treatment Protocols:

1) All Clients must wear a mask. You will be given a new mask and asked to wash your hands with soap and hot water when changing. Afterwards your temperature will be taken.

2) Please remove your street shoes. Bring warm socks if your feet get cold.

3) **Please bring clean comfy clothes to change into.** We do not allow street clothes. The bathroom in my office has been converted into a change room for you.

4) Mute or turn off your cell phone please.

5) You will be asked to sign the consent waiver, and read over a Covid-19 Screening questionnaire before each session.

Remember Please reschedule your appointment via phone or email if you don't feel well, may have been exposed, or or are required to quarantine for any reason. Additionally, If you have been recently vaccinated please reschedule your appointment until 10 days have passed.