Peak Performance Therapy
Alex LaPierre
LMT# 012979
(678) 262-8843
Myofascial Release for Horse and Rider
All disciplines served
pkperformancetherapy.com

COVID-19 Treatment Consent Form

I, _____ (the patient), consent to receive treatment from **Alex LaPierre LMT 012979** with **Peak Performance Therapy, LLC**. during the COVID-19 Pandemic.

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

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 6 feet 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 and the hands-on nature of myofascial release, that I have an increased risk of contracting the virus by receiving treatment.

I understand that the CDC guidelines do not recommend proceeding with any treatment that is non-essential at this time.

I understand that treatment requires contact with my therapist, and that this interaction may not comply with current AMTA, ABMP, or government regulations or suggestions to prevent the spread of COVID-19 _____ (initial).

I understand that I have the right to stop treatment at any time and to wear Personal Protective Equipment (PPE) before, during and after my treatment. I also understand that my Therapist will wear PPE before, during and after my treatment. Further, I understand that PPE worn by myself or the Therapist may impact the level of treatment I may receive _____ (initial).

I understand that the treatment I am receiving is essential to me because of the underlying pain, or conditions that limit my normal day-to-day activities. I confirm I am seeking treatment for a condition that meets these criteria. _____ (Initial)

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

- Fever
- Dry Cough
- Shortness of Breath
- Temperature/Fever
- Persistent pain or pressure in the chest
- Bluish lips or face

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 all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC, should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not traveled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____ (Initial)

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. _____ (Initial)

By signing below, I confirm that I have read and agree to all of the above statements and choose to proceed with treatment at my own risk:

Patient Name:_____

Patient/Guardian Signature:_____

Date:_____

For Practice Use:
Therapist's Signature:_____

Date:_____