CENTURION

Physical Therapy • Personal Training
Pilates • Yoga • Classes • Wellness Services

152 West 57th Street, 6th Floor
New York, NY 10019

# INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

This "Informed consent" acknowledges the risks associated with receiving physical therapy services during a pandemic.

***To proceed with receiving care, I confirm and understand the following:*** ***(Initial Below)***

| | |
|---|---|
| I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to- person contact, in which COVID-19 can be transmitted. | |
| I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. | |
| I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care setting. | |
| I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:<br>*• Fever • Dry Cough • Sore Throat •Shortness of Breath •Runny Nose •Loss of Taste or Smell* | |
| I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT traveled in the past 14 days: 1) Outside of the United States; or 2) Domestically within the United States by commercial airline, bus, or train, except for bordering states CT, MA, NJ, PA, or VT. | |
| I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 and give my express permission to you and the staff at your offices to proceed with providing care. | |

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-10 Pandemic. I confirm all of my questions were answered to my satisfaction.

I have read the above COVID-19 risk Informed Consent To Treat. By signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this Consent to cover the entire course of care from all providers associated with Centurion PT for my present condition and for any future condition(s).

Patient Signature, or Parent/Guardian if patient is a minor: Date: